



Delivery System Reform Incentive Payment (DSRIP) Program Outcome Measure Guide

DSRIP Measure Narrative & Detailed Specification Guide – Version 1.7



Prepared by Office of Quality Assurance and Improvement
NH Department of Health and Human Services (DHHS)
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*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence*

Contents

| | |
|---|-----|
| Change Log..... | iii |
| Glossary | v |
| Introduction | 8 |
| ASSESS_SCREEN.01 – Use of Comprehensive Core Standardized Assessment Process by IDN Primary Care and BH Providers..... | 9 |
| ASSESS_SCREEN.02 – Appropriate Follow-Up for Positive Screenings for Potential Substance Use Disorder and/or Depression by IDN Primary Care and BH Providers..... | 11 |
| ASSESS_SCREEN.03 – Selected US Preventive Services Task Force Services for Behavioral Health Population..... | 14 |
| ASSESS_SCREEN.03_Sub_A – Intimate Partner Violence Screening and Applicable Referrals | 15 |
| ASSESS_SCREEN.03_Sub_B – Blood Pressure Screening | 16 |
| ASSESS_SCREEN.03_Sub_C – Adult Lipid Screening..... | 17 |
| ASSESS_SCREEN.03_Sub_D – Adolescent Tobacco Use Interventions | 18 |
| ASSESS_SCREEN.03_Sub_E – Adult Obesity Screening and Counseling | 20 |
| ASSESS_SCREEN.03_Sub_F – Child Obesity and Overweight Screening and Counseling..... | 21 |
| ASSESS_SCREEN.04 – Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN’s Medicaid Billing Providers | 23 |
| CARE.01 – Mental Health-Focused Measure Summary Score | 25 |
| CARE.01_Sub_A – Antidepressant Medication Management – Continuation Phase..... | 25 |
| CARE.01_Sub_B – Adherence to Antipsychotic Medication for Individuals with Schizophrenia | 26 |
| CARE.01_Sub_D – Metabolic Monitoring for Children and Adolescents on Antipsychotics..... | 28 |
| CARE.01_Sub_E – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications | 29 |
| CARE.01_Sub_F – Diabetes Monitoring for People with Diabetes and Schizophrenia..... | 30 |
| CARE.02 – Adolescent Well-Care Visits..... | 32 |
| CARE.03 – Physical Health-Focused Measures for Behavioral Health Population | 33 |
| CARE.03_Sub_A – Controlling High Blood Pressure | 33 |
| CARE.03_Sub_C – Comprehensive Diabetes Care - HbA1c Control <8.0% | 35 |
| CARE.03_Sub_F – Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroids | 36 |
| CARE.03_Sub_G – Asthma Medication Ratio..... | 37 |
| CARE.04 – Initiation of Alcohol and Other Drug Dependence Treatment | 39 |
| CARE.05 – Engagement of Alcohol and Other Drug (AOD) Dependence Treatment..... | 41 |
| CMHC.02 – Community Mental Health Center First Follow-up Visit Timeliness | 43 |
| CMHC.03 – Community Mental Health Center First Psychiatrist Visit Timelines | 44 |

| | |
|---|-----|
| EXPERIENCE.01 – Experience of Care Survey: Care Coordination Composite Score | 45 |
| HOSP_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population | 47 |
| HOSP_ED.02 – Selected Potentially Avoidable Emergency Department Visits | 48 |
| HOSP_ED.03 – Follow-up After Emergency Department Visit for Mental Illness Within 30 Days | 51 |
| HOSP_ED.04 – Follow-up After Emergency Department Visit for Alcohol and other Drug Dependence within 30 Days | 53 |
| HOSP_INP.01 – Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days. | 55 |
| HOSP_INP.02 – Timely Transmission of Transitional Record After Hospital Discharge | 57 |
| HOSP_INP.03 – Follow-up After Hospitalization for Mental Illness Within 7 Days | 59 |
| HOSP_INP.04 – Follow-up After Hospitalization for Mental Illness Within 30 Days..... | 61 |
| OPIODRX.01 – Extended Daily Dosage of Opioids Greater than 120mg Morphine Equivalent Dose | 63 |
| Appendix A: Integrated Delivery Network Detailed Measure Reporting Specifications | 65 |
| ASSESS_SCREEN.01 - Use of Comprehensive Core Standardized Assessment by the IDN’s Medicaid Billing Providers..... | 65 |
| ASSESS_SCREEN.02 - Appropriate Follow-Up Plan for Positive Screenings for Potential Depression and/or Substance Use Disorder by the IDN’s Medicaid Billing Providers | 71 |
| ASSESS_SCREEN.02-A: Depression | 73 |
| ASSESS_SCREEN.02-B: Substance Use Disorder | 79 |
| ASSESS_SCREEN.03 - Selected U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by the IDN’s Medicaid Billing Providers | 84 |
| ASSESS_SCREEN.03-A: Intimate Partner Violence and Applicable Referrals | 86 |
| ASSESS_SCREEN.03-B: Blood Pressure Screening | 90 |
| ASSESS_SCREEN.03-C: Adult Lipid Screenings..... | 95 |
| ASSESS_SCREEN.03-D: Adolescent Tobacco Use Interventions | 100 |
| ASSESS_SCREEN.03-E: Adult Obesity Screening and Counseling | 105 |
| ASSESS_SCREEN.03-F: Child Obesity Screening and Counseling | 110 |
| ASSESS_SCREEN.04 - Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN’s Medicaid Billing Providers | 116 |
| Appendix B: Measurement Timeline | 122 |

Change Log

| Date | Change |
|---------|---|
| 3/12/18 | V1.0 released |
| 3/27/18 | <p>Addressed the following errata (note, all changes were transcription errors in the Guide that are being corrected to align with the Measure Spreadsheet):</p> <ul style="list-style-type: none"> Corrected age range in CARE.03_Sub_C HbA1c measure description to 18 to 75. Removed mention of attributed population in the HOSP_INP.02 measure. The measure was always intended to be based on a DHHS sample of IDN partner facility discharges regardless of patient attribution. In Appendix B, ASSESS_SCREEN.01 and .02, changed Oct 2019 publication date for the Jan-Jun 2019 data period to P4P and removed Oct 2021 publication date; ASSESS_SCREEN.04 added P4R reporting date for Jan-Jun 2018, changed Oct 2019 publication date for Jan-Jun 2019 data period to P4P and removed Oct 2021 publication date; changed Aug 2020 & 2010 publication to being based on 2019 and 2020 respectively. |
| 3/27/18 | Added further clarification to ASSESS_SCREEN.02 and ASSESS_SCREEN.04 to clarify that the measures are only assessing if follow-up plan (ASSESS_SCREEN.02) or intervention (ASSESS_SCREEN.04) is in place, not the screening itself or patient compliance with the plan or intervention. This clarification can be found as notes in italics in the first section of each measure's description. |
| 5/8/18 | Added outpatient hospital (excluding emergency department) Place of Services 19 and 22 to Office and Office and Community Based definitions. These codes should have been included previously. |
| 6/28/18 | Corrected typo that stated "lower" performance was preferable for HOSP_INP.02 to "higher". |
| 6/28/18 | Added detail to HOSP_INP.03 and HOSP_INP.04 that Community Mental Health Center visits for HEDIS listed procedure codes are included in the numerator even if the individual performing provider is not identified on the claim. |
| 7/11/18 | In Appendix A Detailed Reporting Specifications for measure ASSESS_SCREEN.04, in the Definitions Specific to Measure section, corrected a typo that referred to positive depression screenings instead of positive tobacco use screenings. |
| 7/24/18 | Added ICD-10 diagnosis code M60.9 to ED.02 in the Selected Potentially Avoidable Diagnoses table. This code is in the DSRIP Outcome Measure spreadsheet and should have been included in this list previously. |
| 7/30/18 | Updated Appendix A Measure Flow Charts for ASSESS_SCREEN.02-A and ASSESS_SCREEN.02-B to indicate additional exclusions from the denominator. |
| 11/8/18 | <p>Version 1.7</p> <ol style="list-style-type: none"> Removed measure CMHC.01 Updated narratives and Appendix B for the following measures since they were changed from annual calculation to semi-annual calculation: <p>HOSP_INP.01</p> |

| | <p>HOSP_INP.03</p> <p>HOSP_INP.04</p> <p>CARE.02</p> <p>OPIODRX.01</p> <p>3) Corrected the measurement period for HOSP_ED.01 and HOSP_ED.02.</p> <p>4) In the table for Selected Potentially Avoidable Diagnoses in measure HOSP_ED.02, made the following two updates to the table:</p> <table><tr><th>Old Code/Code Range</th><th>New Code/Code Range</th><th>Description</th></tr><tr><td>M25.5 range, excludes M25.54 Pain in joints of hand range</td><td>M25.5 range</td><td>Pain in joint</td></tr><tr><td>M79.1</td><td>M79.1 range</td><td>Myalgia</td></tr></table> | Old Code/Code Range | New Code/Code Range | Description | M25.5 range, excludes M25.54 Pain in joints of hand range | M25.5 range | Pain in joint | M79.1 | M79.1 range | Myalgia |
|--|---|---------------------|---------------------|-------------|--|-------------|---------------|-------|-------------|---------|
| Old Code/Code Range | New Code/Code Range | Description | | | | | | | | |
| M25.5 range, excludes M25.54 Pain in joints of hand range | M25.5 range | Pain in joint | | | | | | | | |
| M79.1 | M79.1 range | Myalgia | | | | | | | | |

Glossary

Acute Behavioral Health Inpatient Visit - Patient encounter that occurs at a hospital or acute residential psychiatric facility where patients are admitted by the order of a provider for a behavioral health condition. The setting excludes nursing facilities, assisted living facilities, and skilled nursing facilities.

Acute Inpatient Visit – Patient encounters that occur at a hospital facility where patients are admitted by the order of a provider. The setting excludes nursing facilities, assisted living facilities, and skilled nursing facilities.

Attributed Behavioral Health Population – The subset of the Integrated Delivery Network (IDN) Attributed population that DHHS has determined is likely using, at risk for, or in need of behavioral health care (see below item for more information).

Behavioral Health Population – DHHS determined subset of the Medicaid population that is broadly likely using, at risk for, or in need of behavioral health care. In general, a year's worth of pharmacy claims by drug class and medical, behavioral health, and institutional claims and encounters by principal diagnosis are used to determine if a member is in the behavioral health population. DHHS performs this assignment along with assigning attribution. Specifics of DHHS's method for assigning the behavioral health indicator are included in the NH DSRIP Outcome Measure Specifications.

Business Rules – A framework for ensuring DHHS accepts reasonable values for each measure. Wherever possible, DHHS will base business rules on historic data submitted for each measure. DHHS will update and fine tune business rules as more data becomes available. Established business rules appear with the description of each data element within the specification.

For example, if a data value of "0" is submitted for a measure with a business rule "Must be ≥ 1.00 ", the data will be rejected.

Class – Identifies whether the report is a rate, numerator, or denominator.

Data Source/Type – Data that is used to calculate the measure (e.g. administrative data, survey data, health care record review).

Data Source Life Span – the valid data source reporting period for multiple submissions of a measure that describes the lifespan of all submissions. The lifespan is generated from the combination of the Data Source Life Span Start and End Dates (e.g. 2013-12-01 to 2099-12-31). Active measures will have a Data Source Life Span End Date of 2099-12-31. Data submitters should draw data as specified by the Measure Data Source Period Previews.

Data Source Life Span Start Date – Valid data source reporting period start date for multiple submissions of a measure. Range indicates the time period (e.g. using service dates) that a submitter would draw on to calculate the measure (e.g. lifespan of the measure).

Data Source Life Span End Date – Valid data source reporting period end date for multiple submissions of a measure. Range indicates the time period (e.g. using service dates) that a submitter would draw on to calculate the measure (e.g. lifespan of the measure).

Electronic health record (EHR) or other electronic tracking system – Electronic Health Record or other electronic tracking system such as a shared care plan that allows IDN providers to store and query evidence assessments or other activities electronically.

Eligible Population – A detailed description of the population the measure describes, including age ranges, gender, continuous enrollment and other characteristics important for the measure.

Exclusions – Individuals or scenarios that should not be included in the measure.

HEDIS – Healthcare Effectiveness Data and Information Set (HEDIS) is a tool and set of quality measures used by health plans, including NH's Medicaid Managed Care Organizations, to measure performance on care and service delivery for the populations they serve. Many DSRIP measures are based on HEDIS measures.

Identifier – The alpha-numerically unique value for each measure or submeasure. In the case of submeasures, all related submeasures will utilize identifiers with the parent measure identifier as the base

IDN's Medicaid Billing Provider – A provider who is part of the reporting Independent Delivery Network who is enrolled as a NH Medicaid Billing provider.

Last Modified – The date the measure was last changed.

Measure Due Date Previews – Specific due date that the submitter must report by for a specific measure source data period, corresponding to the Measure Data Source Periods.

Measure Data Source Time Period – The generic length of time prescribing the date spans for slices of source data reporting periods that a submitter would draw on to calculate a measure (e.g. 1 year, 2 years, 3 years, 4 years, 5 years, quarter, month, week).

Measure Data Source Period Previews – Specific source data periods (dates) that the submitter must draw from to produce a measure for the specific time period, showing a preview of the next four source data periods. The end date will include the year the data represents from a reporting perspective.

Measure Submission Frequency – The frequency of how often the data submitter will submit data (e.g. annually, quarterly, monthly, or weekly).

IDN's Medicaid Billing Provider – A provider who is part of the reporting Independent Delivery Network who is enrolled as a NH Medicaid Billing provider.

Medicaid Population – For the purpose of DSRIP waiver measurement generally the Medicaid population covers all those people enrolled in Medicaid regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service and regardless of whether the person also has coverage from another source (e.g., Medicare).

Non-Acute Behavioral Health Inpatient Visit – Patient encounter at a psychiatric residential treatment facility, nursing facility, assisted living facility, or skilled nursing facility for long-term care for a behavioral health condition.

Non-Acute Inpatient Visit – Patient encounter at a nursing facility, assisted living facility, or skilled nursing facility.

Office and Community Based Visit – Preventive, medical or behavioral health encounter at the following locations: school, homeless shelter, office, home, assisted living facility, group home, mobile unit, temporary lodging, walk-in retail clinic, place of employment, on or off campus outpatient hospital (excluding emergency department), independent clinic, federally qualified health center, mental health center, non-residential substance abuse treatment facility, comprehensive outpatient rehabilitation facility, public health clinic, and rural health clinic.

Office Based Visit – Medical or behavioral health office visit at the following locations: office, on or off campus outpatient hospital (excluding emergency department), independent clinic, federally qualified health center, mental health center, non-residential substance abuse treatment facility, comprehensive outpatient rehabilitation facility, and rural health clinic.

Outpatient Visit – A patient encounter at a variety of office based settings where medical and behavioral health care are provided. The setting excludes inpatient settings.

Submission Due Date Lag Period – The length of time, in whole months or whole days, from the end of each specific Measure Data Source Time Period by which a data submitter must submit data (e.g. three months, six months, annual).

Summary of Measure Changes – Changes that have occurred to the measure since the previous version.

Technical Definition – Specific details about the measure, submeasure, or data element.

Type – The format the value is submitted. Typically this is numeric.

USPSTF – U.S. Preventive Services Task Force is an independent panel (appointed by a federal agency) of national experts in disease prevention and evidence-based medicine that works to improve the health of the population by making evidence-based recommendations about clinical preventive services.

Well Care Visit – Comprehensive preventive medicine evaluation and management visits that may or may not include evaluation and management of specific conditions. Visits are billed to payers with a procedure code in the range 99381 – 99397.

Introduction

The Delivery System Reform Incentive Payment (DSRIP) Program Measure Narrative Guide is a high-level guide to the outcome measures used by the NH DSRIP program to evaluate Integrated Delivery Network (IDN) performance for incentive payment. These measures are part of CMS approved protocols (and hence the IDN contracts) and also allow the Department to support DSRIP oversight and evaluate overall program impact.

The intent behind creating this guide is to create a simplified plain English version of the detailed definitions of each measure with an intended audience being DHHS/IDN management, leads and project managers, not information systems or quality data analysts.

For more detail, each performance measure has a list of more technical definitions that are very important to each measure in the DSRIP Outcome Measures spreadsheet located on the DSRIP Quality Performance webpage (<https://www.dhhs.nh.gov/dphs/oqai/dsrip-quality-perf>). If you want to know more about a measure, the spreadsheet is a good first step for the measures DHHS is calculating (some with data supplied by IDNs).

For the measures that IDN's are fully responsible for calculating (ASSESS_SCREEN.01 through 04), refer to Appendix A: DSRIP IDN Reported Measure Specifications. The Appendix provides lower level details that would be required by staff gathering this information or IT support staff helping with data collection and reporting (previously this information was maintained in a separate document).

For the measures that DHHS has the responsibility for calculating, the specifications for any related measurement effort are followed. For example, if a measure is based on a HEDIS measure, then the HEDIS manual is followed to calculate the measure. Due to this there is no separate specification guide for DHHS calculated measures beyond the DSRIP Outcome Measurements Final spreadsheet. Where the measure DHHS calculates is a DHHS derived measure, the full detail is included in the spreadsheet.

In addition to the information on the measures, Appendix B: Measurement Timeline is a quick tool that summarizes when a measure is due, who is responsible for reporting, what the payment basis is and the measurement period.

This guide will be updated periodically to reflect changes in the DSRIP program and provide further clarity as needed. The IDN's will be notified when changes are made.

ASSESS_SCREEN.01 – Use of Comprehensive Core Standardized Assessment Process by IDN Primary Care and BH Providers

Percent of Medicaid patients age 12 and older seen by an IDN partner primary care or behavioral health provider during the six month measurement period, who have an up to date complete Comprehensive Core Standardized Assessment (CCSA) within 12 months of the patient's most recent visit as indicated in the provider's electronic health record or other electronic tracking system. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure.

The CCSA is counted when it was completed in accordance to the IDN/Provider protocols and occurred during the qualified visit or 12 months prior. CCSAs completed in the past 12 months are counted regardless of Medicaid eligibility at the time of the completed CCSA.

A completed CCSA is defined in the DHHS *Comprehensive Core Standardized Assessment Approach Document* available to the IDN leads. The assessment must include all of the following domains to be complete: demographic, medical, substance use including tobacco use and SBIRT screening, housing, family & support services, education, employment and entitlement, legal, risk assessment, including suicide risk, functional status (activities of daily living, instrumental activities of daily living, cognitive functioning), pediatric developmental screening using age appropriate standardized and validated tools, and depression screening using standardized and validated tools.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members:

- Age 12 and older; and
- With an office or community based visit at the IDN's Medicaid physical or behavioral health provider during the six month measurement period while enrolled in Medicaid.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined as of the date of the office or community based visit; and
- See Glossary for the definition of office or community based visits.

What is excluded?

Patients with no visits or only inpatient and emergency department hospital visits during the reporting period are not included in the measure.

How is the measure calculated?

The IDN's will calculate and submit the measure semi-annually. Each report will measure performance for 6 months of the calendar year.

The first submission of data due April 2018 is for the second half of 2017 (July to December) and will be a pilot. Along with the submission IDN's must explain any gaps in reporting (see below for elements to report). IDN's will continue to calculate and submit the measure for each 6 month performance period through last performance period at the end of the 2020 calendar year.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with current assessment;
- Denominator for number of patients seen during the period;
- Percentage of patients with current assessments; and
- Table outlining the specific gaps in report that the IDN has for numerator or denominator (for pilot submission). At a minimum, list in a table each practice that is not submitting or submitting incompletely, the reason for the underreporting, the resolution to correct the underreporting, and the expected date of compliance.

How does this outcome metric impact payment?

IDN's ability to submit data for the 2017 pilot and calendar year 2018 will be used to determine performance-based incentive funding.

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

Statewide progress to meet goals in calendar years 2019 and 2020 will be used to evaluate statewide performance that may impact state funding.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

ASSESS_SCREEN.02 – Appropriate Follow-Up for Positive Screenings for Potential Substance Use Disorder and/or Depression by IDN Primary Care and BH Providers

Percent of positive screenings for potential substance use disorder and/or depression for Medicaid patients age 12 and older seen by an IDN partner primary care or behavioral health provider during the six month measurement period, with an appropriate follow-up plan (per IDN protocols) documented in the patient's electronic health record (EHR) on the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure.

There are two submeasures reported for this measure:

- Percent of positive screenings for substance use disorder that have a follow-up plan documented; and
- Percent of positive screenings for depression that have a follow-up plan documented.

Note: The measure only assesses whether the follow-up plan is in place for positive screenings. It does not assess whether screening occurred or whether any follow-up plan has actually been carried out by the patient. The DSRIP ASSESS_SCREEN.02 measure tracks follow-up plan events, not people.

Appropriate follow up plan is defined in accordance with the IDN's protocols.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members:

- Age 12 and older;
- With an office or community based visit at the IDN's Medicaid physical or behavioral health provider during the six month measurement period while enrolled in Medicaid; and
- With a positive screening for potential substance use disorder and/or depression during the office or community based visit.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined as of the date of the office based visit; and
- See Glossary for definition of office or community based visits.

What is excluded?

Positive screenings are excluded when the following conditions are documented:

- Patient refuses to participate in a follow-up plan;
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status;

- Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools. For example: certain court appointed cases or cases of delirium; or
- Any other exclusion documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

How is the measure calculated?

The IDN’s will calculate and submit the measure semi-annually. Each report will measure performance for 6 months of the calendar year.

The first submission of data due April 2018 is for the second half of 2017 (July to December) and will be a pilot. Along with the submission IDN’s must explain any gaps in reporting (see below for elements to report). IDN’s will continue to calculate and submit the measure for each 6 month performance period through last performance period at the end of the 2020 calendar year.

What is the IDN’s responsibility for calculating this measure?

Substance Use Disorder components:

- Numerator for positive substance use disorder screening follow-ups documented,
- Denominator for positive substance use disorder screenings in period,
- Percentage of positive substance use disorder screenings with follow-up documented, and
- A table outlining the specific gaps in reporting of substance use disorder screening and follow-up that the IDN has for the numerator or denominator (for pilot submission). At a minimum, list in a table each practice that is not submitting or submitting incompletely, the reason for the underreporting, the resolution to correct the underreporting, and the expected date of compliance.

Depression components:

- Numerator for positive depression screening follow-up documented,
- Denominator for positive depression screening in period,
- Percentage of positive depression screenings with follow-up documented, and
- A table outlining the specific gaps in reporting of depression screening and follow-up that the IDN has for the numerator or denominator (for pilot submission). At a minimum, list in a table each practice that is not submitting or submitting incompletely, the reason for the underreporting, the resolution to correct the underreporting, and the expected date of compliance.

How does this outcome metric impact payment?

IDN’s ability to submit data for the 2017 pilot and calendar year 2018 will be used to determine performance-based incentive funding.

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

ASSESS_SCREEN.03 – Selected US Preventive Services Task Force Services for Behavioral Health Population

Percent of IDN's attributed behavioral health patients seen at the IDN's Medicaid Billing providers where the patient's electronic health record (EHR) or other electronic tracking system contains evidence of selected recommended USPSTF A&B Services.

Individual measures include:

- ASSESS_SCREEN.03_SUB_A – Intimate Partner Violence Screening and Applicable Referrals;
- ASSESS_SCREEN.03_SUB_B – Blood Pressure Screening;
- ASSESS_SCREEN.03_SUB_C – Adult Lipid Screening;
- ASSESS_SCREEN.03_SUB_D – Adolescent Tobacco Use and Interventions;
- ASSESS_SCREEN.03_SUB_E – Adult Obesity Screening and Counseling; and
- ASSESS_SCREEN.03_SUB_F – Child Obesity and Overweight Screening and Counseling.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population. See sub-measure for specific details.

What is excluded?

See sub-measure for specific details.

How is the measure calculated?

The IDN's will calculate and submit the measure annually. Each report will measure performance for the calendar year.

The first submission of data due August 2019 will be for the 2018 calendar year. IDN's will continue to calculate and submit the measure for each 12 month performance period through last performance period at the end of the 2020 calendar year.

How does this outcome metric impact payment?

IDN's ability to submit data for the submeasures for calendar year 2018 (due August 2019) will be used to determine performance-based incentive funding.

IDN annual performance across all submeasures combined in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the IDN's responsibility for calculating this measure?

The measure was developed by DHHS as part of the DSRIP project.

See sub-measure for specific details.

ASSESS_SCREEN.03_Sub_A – Intimate Partner Violence Screening and Applicable Referrals

Percent of Medicaid patients in the IDN's attributed behavioral health population, females age 18 through 49 seen by the IDN's by an IDN partner primary care or behavioral health provider providers for a well care visit during the calendar year, who are screened for intimate partner violence and provided interventions for positive results, as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Screenings must be conducted with an evidenced-based screening tool for intimate partner violence.

Interventions may include counseling, home visits, information cards, referrals to community services and mentoring services.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Age 18 through 49;
- Female;
- With a well care (i.e., preventive medicine) visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid. While behavioral health providers at this time typically do not perform well care visits, the measure does not preclude the possibility that they do occur or might occur in the future.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the well care visit; and
- Attributed behavioral health population is determined as of the end of the calendar year.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with intimate partner violence screening and applicable referrals during the well care visit;
- Denominator for the number of females 18-49 with a well care visit during the measurement period;
- Percentage of patients with current screening and applicable referrals; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows U.S. Preventive Services Task Force (USPSTF) guidelines found at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening>

ASSESS_SCREEN.03_Sub_B – Blood Pressure Screening

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 18 and older seen by an IDN partner primary care or behavioral health provider for an office visit during the calendar year, who have a current blood pressure screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met. Patients seen only at behavioral health providers who do not routinely do blood pressure screenings must still be reported in the denominator.

A current blood pressure screening is considered:

- Age 18-39 once every 3 years.
- Age 40 years or older annually.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Age 18 and older;
- With an office visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the most recent visit;
- Attributed behavioral health population is determined as of the end of the calendar year; and
- See Glossary for definition of office based visits.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with a current blood pressure screening;
- Denominator for the number of patients seen during the period;
- Percentage of patients with current blood pressure screening; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows U.S. Preventive Services Task Force (USPSTF) guidelines found at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/high-blood-pressure-in-adults-screening>

ASSESS_SCREEN.03_Sub_C – Adult Lipid Screening

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 45 and older (females 55 and older) seen by an IDN partner primary care or behavioral health provider for an office visit during the measurement who have a current lipid screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met. Patients seen only at behavioral health providers who do not routinely do lipid screenings must still be reported in the denominator.

Current screening is defined as:

- Males age 45 through 65, and females age 55 through 65 once every 2 years; and
- Age 65 and older annually.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Males age 45 and older and Females age 55 and older;
- With an office visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the most recent visit;
- Attributed behavioral health population is determined as of the end of the calendar year; and
- See Glossary for definition of office based visits.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with a current lipid screening;
- Denominator for the number of patients 45 and older (females 55 and older) seen during the period;
- Percentage of patients seen during the measurement period with an up to date lipid screening; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows the American Association of Clinical Endocrinologist and American College of Endocrinology Guidelines for Management of Dyslipidemia and Prevention of Cardiovascular Disease.

ASSESS_SCREEN.03_Sub_D – Adolescent Tobacco Use Interventions

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 12 through 17 seen by an IDN partner primary care or behavioral health provider for a well care visit during the calendar year that are provided brief counseling or education to prevent smoking as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Brief counseling and education includes face-to-face or phone interactions with a care provider, print materials, videos, and computer applications.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Age 12 through 17;
- With a well care (i.e., preventive medicine) visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid. While behavioral health providers at this time typically do not perform well care visits, the measure does not preclude the possibility that they do occur or might occur in the future.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the well care visit; and
- Attributed behavioral health population is determined as of the end of the calendar year by DHHS.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with a brief counseling and education to prevent smoking at the end of the well care visit;
- Denominator for number of patients age 12-17 with a well care visit during the measurement period;
- Percentage of patients with brief counseling and education to prevent smoking; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows U.S. Preventive Services Task Force (USPSTF) guidelines found at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions>

ASSESS_SCREEN.03_Sub_E – Adult Obesity Screening and Counseling

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 18 and older seen by an IDN partner primary care or behavioral health provider for a well care visit during the calendar year who have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Obesity screening should measure the patient's Body Mass Index (BMI).

Patients with a Body Mass Index ≥ 30 should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Age 18 and older;
- With a well care (i.e., preventive medicine) visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid. While behavioral health providers at this time typically do not perform well care visits, the measure does not preclude the possibility that they do occur or might occur in the future.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the well care visit; and
- Attributed behavioral health population is determined as of the end of the calendar year by DHHS.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with a current screening and applicable referrals at the end of the well care visit;
- Denominator for number of adults age 18 and older with a well care visit during the measurement period;
- Percentage of patients with current screening and applicable referrals; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows U.S. Preventive Services Task Force (USPSTF) guidelines found at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/obesity-in-adults-screening-and-management>

ASSESS_SCREEN.03_Sub_F – Child Obesity and Overweight Screening and Counseling

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 6 through 17 seen by an IDN partner primary care or behavioral health provider for a well care (i.e., preventive medicine) visit during the calendar year that have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit.

Obesity screening should measure the patient's Body Mass Index (BMI).

Patients with BMI $\geq 95^{\text{th}}$ percentile (using Center for Disease Control and Prevention growth charts) should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed behavioral health population:

- Age 6 through 17;
- With a well care (i.e., preventive medicine) visit at the IDN's Medicaid physical or behavioral health provider during the calendar year while enrolled in Medicaid. While behavioral health providers at this time typically do not perform well care visits, the measure does not preclude the possibility that they do occur or might occur in the future.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined at the time of the well care visit; and
- Attributed behavioral health population is determined as of the end of the calendar year by DHHS.

What is excluded?

None.

How is the measure calculated?

The IDN's will calculate and submit the measure annually for calendar years 2019 and 2020.

What is the IDN's responsibility for calculating this measure?

- Numerator for the number of patients in the denominator with a current screening and applicable referrals at the end of the well care visit;
- Denominator for the number of children age 6 through 17 with a well care visit during the measurement period;
- Percentage of patients with current screening and applicable referrals; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

The measure follows U.S. Preventive Services Task Force (USPSTF) guidelines found at:

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening>

ASSESS_SCREEN.04 – Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN’s Medicaid Billing Providers

Percent of positive screenings for tobacco use for Medicaid patients age 18 and older seen by an IDN partner primary care or behavioral health provider for an office or community based visit during the six month measurement period, who received a cessation counseling intervention as documented in the patient’s electronic health record (EHR) on the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Cessation counseling includes brief counseling and/or pharmacotherapy.

A higher rate indicates better performance.

Note: The measure only assesses whether the intervention occurred following a positive screening. It does not assess whether screening occurred or whether the intervention was successful. Because of this the measure does not need to rely on the 24 month lookback like the PQRS measure that assesses screening and intervention combined. The DSRIP ASSESS_SCREEN.04 measure tracks intervention events in response to positive screenings, not people.

Who is the eligible population?

Medicaid members:

- Age 18 and older; and
- With an office or community based visit at the IDN’s Medicaid physical or behavioral health provider during the six month measurement period.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) at the time of the visit;
- Age is determined as of the date of the office or community based visit; and
- See Glossary for definition of office or community based visits.

What is excluded?

None.

How is the measure calculated?

The IDN’s will calculate and submit the measure semi-annually. Each report will measure performance for 6 months of the calendar year.

The first submission of data due October 2018 is for the first half of 2018 (January to June) and will be a pilot. Along with the submission IDN’s must explain any gaps in reporting. IDN’s will continue to calculate and submit the measure for each 6 month performance period through last performance period at the end of the 2020 calendar year.

What is the IDN's responsibility for calculating this measure?

- Numerator for number of patients in the denominator with an appropriate follow-up plan;
- Denominator for number of patients with a positive screening of tobacco use, seen during the measurement period;
- Percentage of patients with appropriate follow-up plan; and
- Narrative outlining the specific gaps in report that the IDN has for numerator or denominator (Calendar year 2018 only).

How does this outcome metric impact payment?

IDN's ability to submit data for calendar year 2018 will be used to determine performance-based incentive funding (as a pilot, with gaps documented in the first half of the year, and complete data for the second half of the year).

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

Please refer to Appendix A: DSRIP IDN-reported Measure Specifications Final Version for more detailed descriptions and specifications of this measure.

CARE.01 – Mental Health-Focused Measure Summary Score

Summary score of mental health-focused HEDIS measures for Medicaid patients in the IDN's attributed population.

The summary score is a combination of the numerators and denominators of the five mental health HEDIS measures below (note, identifier Sub C is no longer used).

- CARE.01_SUB_A – Antidepressant Medication Management – Continuation Phase;
- CARE.01_SUB_B – Adherence to Antipsychotic Medication for Individuals with Schizophrenia;
- CARE.01_SUB_D – Metabolic Monitoring for Children and Adolescents on Antipsychotics;
- CARE.01_SUB_E – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications; and
- CARE.01_SUB_F – Diabetes Monitoring for People with Diabetes and Schizophrenia.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed population. See sub-measure for more specific details.

What is excluded?

See sub-measure for specific details.

How is the measure calculated?

See sub-measure for specific details.

How does this outcome metric impact payment?

IDN annual performance across all submeasures combined in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the IDN's responsibility for calculating this measure?

None.

What is the definition source of this measure?

The measure is a combination of HEDIS measures maintained by the National Committee for Quality Assurance of Health Plans (NCQA).

CARE.01_Sub_A – Antidepressant Medication Management – Continuation Phase

Percent of Medicaid patients in the IDN's attributed population age 18 and older who were treated with an antidepressant for a diagnosis of major depression during the measurement period who remained on medication for at least six months.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 18 and older;
- With diagnosis of major depression as a result of an inpatient, outpatient, or ED visit; and
- With a new prescription for an antidepressant during the measurement period.

A new prescription is defined as:

- Being filled before April 30th of the calendar year; and
- The member not being treated by antidepressants for up to 105 days prior to the current prescription.

Note:

- Medicaid members must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 105 days prior to the start of the prescription through 231 days after. One gap in enrollment of 45 days is allowed;
- Age is determined as of April 30th of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of inpatient and outpatient visits.

What is excluded?

Members in hospice.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of depression will be identified using ICD-10 codes in claims and encounter data. Antidepressant prescriptions will be identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (AMM) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. AMM has two rates, but only the effective continuation phase treatment measure is being used for DSRIP.

CARE.01_Sub_B – Adherence to Antipsychotic Medication for Individuals with Schizophrenia

Percent of Medicaid patients in the IDN's attributed population age 19 through 64 with a diagnosis of schizophrenia during the calendar year, who remained on antipsychotic medication for at least 80% of the treatment period.

The treatment period is time between the first dispersion of antipsychotic medication and the end of the calendar year.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 19 through 64;
- With a diagnosis of schizophrenia resulting from an behavioral health inpatient (acute or non-acute), outpatient, partial hospitalization, or emergency department visit during the calendar year; and
- With at least two dispersions of antipsychotic medication during the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of behavioral health inpatient and outpatient visits.

What is excluded?

Members:

- In hospice;
- With a diagnosis of dementia; or
- Who have fewer than two antipsychotic medication dispensing events.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of schizophrenia will be identified using ICD-10 codes in claims and encounter data. Antipsychotic prescriptions will identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (SAA) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.01_Sub_D – Metabolic Monitoring for Children and Adolescents on Antipsychotics

Percent of Medicaid patients in the IDN's attributed population age 1 through 17 who had two or more antipsychotic prescriptions dispensed during the calendar year and had metabolic testing.

Metabolic testing is considered a blood glucose test or HbA1C and either a LDL-C or cholesterol test.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 1 through 17 (grouped by age 1-5, 6-11, 12-17); and
- With at least two dispersion of antipsychotic medications during the calendar year (medications can be the same or different).

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year; and
- Attributed population is determined at the end of the calendar year by DHHS.

What is excluded?

Members in hospice.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Metabolic testing will be identified using procedure codes in claims and encounter data. Antipsychotic prescriptions will be identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (APM) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.01_Sub_E – Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications

Percent of Medicaid patients in the IDN's attributed population age 18 through 64 with a diagnosis schizophrenia or bipolar disorder during the calendar year, who were dispensed an antipsychotic medication and had a diabetes screening during the calendar year.

Diabetes screening is a glucose or an HbA1c test.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 18 through 64;
- With a diagnosis of schizophrenia resulting from an behavioral health inpatient (acute or non-acute), outpatient, partial hospitalization, or emergency department visit during the calendar year; and
- With at least one dispersion of an antipsychotic medications during the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of behavioral health inpatient and outpatient visits.

What is excluded?

Members:

- In hospice; or
- With diabetes as indicated by:
 - A diagnosis of diabetes resulting from an inpatient (acute or non-acute), outpatient, or emergency department visit two year prior to the end of the calendar year; or
 - Dispensing of diabetes medication two year prior to the end of the calendar year.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of diabetes, schizophrenia and bi-polar disorder will be identified by using ICD-10 codes in claims and encounter data. Glucose and HbA1c tests will be identified using procedure codes in claims and encounter data. Antipsychotic prescriptions will identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (SSD) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.01_Sub_F – Diabetes Monitoring for People with Diabetes and Schizophrenia.

Percent of Medicaid patients in the IDN's attributed population age 18 through 64 with a diagnosis of schizophrenia during the calendar year and a diagnosis of diabetes within the prior or current calendar year, who had a LDL-C and an HbA1c test during the calendar year.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 18 through 64;
- With a diagnosis of schizophrenia resulting from an behavioral health inpatient (acute or non-acute), outpatient, partial hospitalization, or emergency department visit during the calendar year; and
- With diabetes as indicated by:
 - A diagnosis of diabetes resulting from an inpatient (acute or non-acute), outpatient, or emergency department visit two year prior to the end of the calendar year; or
 - Dispensing of diabetes medication two year prior to the end of the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of behavioral health inpatient and outpatient visits.

What is excluded?

Members in hospice.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of diabetes, gestational diabetes, steroid-induced diabetes, and schizophrenia will be identified by using ICD-10 codes in claims and encounter data. LDL-C and HbA1c tests will be identified using procedure codes in claims and encounter data. Diabetes prescriptions will be identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (SMD) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.02 – Adolescent Well-Care Visits

Percent of Medicaid patients in the IDN's attributed population age 12 through 21 years of age who had at least one well-care visit during the rolling measurement year calculated at six month intervals (e.g., 7/1/18 to 6/30/19 and 1/1/19 to 12/31/19).

Well-care visit must be conducted by a primary care provider or OB/GYN.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN health population who were age 12 through 21.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire rolling measurement year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the measurement period; and
- Attributed population is determined at the end of the measurement period by DHHS.

What is excluded?

Members in hospice.

How is the measure calculated?

DHHS will calculate the measure using claims and encounter data. Well care visits will be identified using procedure codes contained in the data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the source of the definition of this measure?

This HEDIS (AWC) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Note that the measure is modified to be calculated semi-annually.

CARE.03 – Physical Health-Focused Measures for Behavioral Health Population

Summary score of physical health-focused HEDIS measures for Medicaid patients in the IDN's attributed behavioral health population.

The summary score is calculated by combining the numerators and denominators of four physical health HEDIS measures below (note, identifiers Sub B, D, E are no longer used).

- CARE.03_SUB_A – Controlling High Blood Pressure;
- CARE.03_SUB_C – HbA1c Control <8.0%;
- CARE.03_SUB_F – Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroids; and
- CARE.03_SUB_G – Medication Management for People with Asthma.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed population. See sub-measure for specific details.

What is excluded?

See sub-measure for specific details.

How is the measure calculated?

DHHS will calculate the measure. CARE.03_SUB_A and CARE.03_SUB_C will require the IDNs to submit data to DHHS on a sample of members. See each sub-measure for more specifics.

What is the IDN's responsibility for calculating this measure?

See sub-measure for specific details.

How does this outcome metric impact payment?

The first submission of data by the IDNs to DHHS on a sample of members for CARE.03_SUB_A and CARE.03_SUB_C is due October 2019. The IDN's ability to report the data will be used to determine performance based incentives for calendar year 2018.

IDN annual performance across all submeasures combined in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

The measure is a combination of HEDIS measures maintained by the National Committee for Quality Assurance of Health Plans (NCQA).

CARE.03_Sub_A – Controlling High Blood Pressure

Percent of Medicaid patients in the IDN's attributed behavioral health population age 18 through 85 who had a diagnosis of hypertension in the first six months of the calendar year and whose blood pressure was adequately controlled following the diagnosis through the end of the calendar year.

Adequate control is defined as:

- Members 18-59 years of age whose blood pressure was <140/90mm Hg; and
- Members 60-85 years of age:
 - Without diabetes whose blood pressure was <140/90 mm Hg; and
 - With diabetes who blood pressure was <150/90 mm Hg.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN behavioral health population:

- Age 18 to 85 years old; and
- With a diagnosis of hypertension resulting from an outpatient visit that occurred in the first six months of the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of outpatient visits.

What is excluded?

Members:

- In hospice; or
- Receiving Medicare and age 65 as of January 1 of the measurement who are residing in a long-term care facility (e.g., nursing home, assisted living, hospice) any time during the measurement period; or
- Members with gestational diabetes.

Blood pressure readings when taken:

- During an acute inpatient stay or at an ED visit;
- On the same day as other tests, procedures, or treatment changes; and
- By the member.

How is the measure calculated

DHHS will jointly calculate the measure with the IDNs using claims, encounter, and electronic health record data from the IDN's. The IDNs will be required to submit data to DHHS on a sample of members.

A sample of members will be used to determine a rate of members with adequate controlled blood pressure. The sample rate is then applied total eligible population in the IDN's behavioral health attributed population.

Blood pressure readings will be identified through IDN electronic health record data. Diagnosis of hypertension will be identified using ICD-10 codes in claims and encounter data. IDNs may gain credit for a numerator compliant reading provided by another IDN.

What is the IDN's responsibility for calculating this measure?

DHHS will provide a sample of members to each IDN. The IDN will provide DHHS with the results of each member's most recent blood pressure reading through electronic health records data.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (CBP) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.03_Sub_C – Comprehensive Diabetes Care - HbA1c Control <8.0%

Percent of Medicaid patients in the IDN's attributed behavioral health population age 18 through 75 with a diagnosis of diabetes during the prior or current calendar year, whose most recent HbA1c test during the calendar year was <8.0%.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN behavioral health population:

- Age 18 through 75;
- With diabetes as indicated by:
 - A diagnosis of diabetes resulting from an inpatient (acute or non-acute), outpatient, or emergency department visit two year prior to the end of the calendar year; or
 - Dispensing of diabetes medication two year prior to the end of the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of the calendar year;
- Attributed population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of outpatient visits.

What is excluded?

- Members in hospice; or
- Members with gestational diabetes

How is the measure calculated

DHHS will jointly calculate the measure with the IDNs using claims, encounter, and electronic health record data from the IDN's. The IDNs will be required to submit data to DHHS on a sample of members.

A sample of members will be used to determine a rate of members whose most recent HbA1c test result is <8.0%. The sample rate is then applied total eligible population in the IDN's behavioral health attributed population.

HbA1c test results will be identified through IDN electronic health record data. Diagnosis of diabetes will be identified using ICD-10 codes in claims and encounter data. Medication dispensing will be identified by National Drug Codes (NDC) in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

DHHS will provide a sample of members to each IDN. The IDN will provide DHHS with the results of each member's most recent HbA1c test results through electronic health records data. IDNs may gain credit for a numerator compliant reading provided by another IDN.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (CDC) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. CDC has multiple rates, but only the HbA1c Control <8.0% measure is being used for DSRIP.

CARE.03_Sub_F – Pharmacotherapy Management of COPD Exacerbation Systemic Corticosteroids

Percent of acute inpatient discharges and emergency department visits, where a Medicaid patient in the IDN's attributed behavioral health population age 40 and older had a diagnosis of COPD prior to December 1st of the calendar year, was dispensed or had an active systemic corticosteroid prescription within 14 days.

Corticosteroids are used to provide relief to inflamed areas of the body.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN behavioral health population:

- Age 40 and older; and
- With a diagnosis of COPD resulting from an emergency department visit or acute inpatient discharge that occurred prior to December 1st of the measurement year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 30 calendar days after the date of the discharge or emergency department visit;
- Age is determined at the end of the calendar year; and
- Attributed behavioral health population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of acute inpatient visits.

What is excluded?

Members in hospice.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of COPD will be identified using ICD-10 codes in claims and encounter data. Corticosteroid prescriptions will be identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (PCE) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. PCE has two rates, but only the systemic corticosteroid rate is being used.

CARE.03_Sub_G – Asthma Medication Ratio

Percent of Medicaid patients in the IDN's attributed behavioral health population age 5 through 64 who had a diagnosis of persistent asthma in the prior or current calendar year and had a ratio controller medication to total asthma medications of .50 or greater during the calendar year.

Persistent asthma is a more severe form of asthma.

Controller medications are used to achieve and maintain control of severe asthma. Other asthma medications are used as quick-reliever medications. A ratio of .50 or higher for controller medication to total asthma medications can indicate more appropriate management of the disease.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN behavioral health population:

- Age 5 through 64 (grouped by age 5-11, 12-18, 19-50, 51-64); and
- With persistent asthma as identified by:

- A principal diagnosis resulting from an acute inpatient, outpatient, or emergency department visit occurring two years prior to the end of the calendar year;
- Medication dispensing events for any controller or reliever medications occurring two years prior to the end of the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for two years prior to the end of the calendar year, with only one gap of up to 45 days allowable in each continuous year.
- Age is determined at the end of the calendar year;
- Attributed behavioral health population is determined at the end of the calendar year by DHHS; and
- See Glossary for definition of acute inpatient visits.

What is excluded?

Members:

- In hospice;
- With no asthma medications dispensed during the calendar year; or
- With any history of the following diagnosis:
 - Emphysema;
 - COPD;
 - Obstructive chronic bronchitis;
 - Chronic respiratory conditions due to fumes/reports;
 - Cystic fibrosis; or
 - Acute respiratory.

How is the measure calculated

DHHS will calculate the measure using claims, and encounter data. Diagnosis of persistent asthma will be identified using ICD-10 codes in claims and encounter data. Asthma prescriptions will identified by National Drug Codes in pharmacy claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

Submeasure will contribute to overall measure performance.

What is the definition source of this measure?

This HEDIS (AMR) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure.

CARE.04 – Initiation of Alcohol and Other Drug Dependence Treatment

Percent of Medicaid patients in the IDN's attributed population age 13 and older, with a new episode of Alcohol and Other Drug Dependence (AOD) during the ten and a half month measurement period who had a treatment service within 14 days of the initial treatment visit.

Episode of AOD includes:

- Diagnosis for AOD abuse or dependence resulting from an outpatient, inpatient (acute or non-acute), emergency department, detoxification, or telephone visit.
- Diagnosis for AOD abuse or dependence resulting from an online assessment.

Diagnosis for AOD includes abuse or dependence from alcohol, opioids, and/or other drugs.

Treatment services are considered inpatient AOD admission, outpatient visits, intensive outpatient encounters, partial hospitalization, telehealth, or medication assisted treatment.

A higher rate indicates better performance.

See Glossary for definition of inpatient and outpatient visits.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 13 and older (grouped by age 13-17, 18 and older);
- With a new episode of AOD (described above) occurring:
 - Between July 1 and May 15th for the annual reporting period ending on June 30th; or
 - Between Jan 1 and Nov 15th for the annual reporting period ending on December 31st.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 60 days prior and 48 days after the new episode of AOD;
- Age is determined at the end of the calendar year; and
- Attributed population is determined at the end of the calendar year by DHHS.

What is excluded?

Members in hospice.

How is the measure calculated?

DHHS will calculate the measure using claims, and encounter data. Diagnosis of AOD will be identified using ICD-10 codes in claims and encounter data. Treatment visits will identified by procedure codes in claims and encounter data.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

Statewide progress to meet goals in calendar years 2019 and 2020 will be used to evaluate statewide performance that may impact state funding.

What is the definition source of this measure?

This modified HEDIS (IET) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Modifications include NH utilized treatment codes and calculating the measure for the July to June period in addition to the January to December period.

CARE.05 – Engagement of Alcohol and Other Drug (AOD) Dependence Treatment

Percent of Medicaid patients in the IDN's attributed population age 13 and older, with a new episode of Alcohol and Other Drug Dependence (AOD) during the ten and a half month measurement period who had two or more additional treatment services within 34 days of the initial treatment visit.

Episode of AOD includes:

- Diagnosis for AOD abuse or dependence resulting from an outpatient, inpatient (acute or non-acute), emergency department, detoxification, or telephone visit.
- Diagnosis for AOD abuse or dependence resulting from an online assessment.

Diagnosis for AOD includes abuse or dependence from alcohol, opioids, and/or other drugs.

Treatment services are considered inpatient AOD admission, outpatient visits, intensive outpatient encounters, partial hospitalization, telehealth, or medication assisted treatment.

A higher rate indicates better performance.

See Glossary for definition of inpatient and outpatient visits.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 13 and older (grouped by age 13-17, 18 and older);
- With a new episode of AOD (described above) occurring:
 - Between July 1 and May 15th of the calendar year for semi-annual reporting period ending on June 30th; or
 - Between Jan 1 and Nov 15th of the calendar year for semi-annual reporting period ending on December 31st.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 60 days prior and 48 days after the new episode of AOD;
- Age is determined at the end of the calendar year; and
- Attributed population is determined at the end of the calendar year by DHHS.

What is excluded?

Members in hospice.

How is the measure calculated?

DHHS will calculate the measure using claims, and encounter data. Diagnosis of AOD will be identified using ICD-10 codes in claims and encounter data. Treatment visits will be identified by procedure codes in claims and encounter data.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This modified HEDIS (IET) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Modifications include NH utilized treatment codes.

CMHC.02 – Community Mental Health Center First Follow-up Visit

Timeliness

Percent of Medicaid patients in the IDN's attributed population who are newly eligible for CMHC services during the six month reporting period, with a follow-up visit 7 calendar days following the intake appointment.

Eligibility for CMHC services is determined by the Bureau of Mental Health criteria.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Any age (grouped by age under 18, 18 and older); and
- Newly eligible for CMHC services as determined by an intake appointment that occurred within the six month measurement period.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 7 calendar days after the intake appointment.
- Age is determined at the end of the six month measurement period; and
- Attributed population is determined at the end of the six month measurement period by DHHS.

What is excluded?

Members with an intake appointment within 7 calendar days of the end of the six month measurement period.

How is the measure calculated?

DHHS will calculate the measure using the DHHS Community Mental Health Center Phoenix Encounter Data Reporting System.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

The measure is created by DHHS.

CMHC.03 – Community Mental Health Center First Psychiatrist Visit Timelines

Percent of Medicaid patients in the IDN's attributed population who are newly eligible for CMHC services during the six month measurement period, with a psychopharmacology appointment that occurred within 30 calendar days following the intake appointment.

The psychopharmacology visit for assessing medication must be conducted by a Psychiatrist or Advanced Practice Registered Nurse (APRN).

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Any age (grouped by age under 18, 18 and older); and
- Newly eligible for CMHC services as determined by an intake appointment that occurred within the six month measurement period.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for 30 calendar days after the intake appointment.
- Age is determined at the end of the six month measurement period; and
- Attributed population is determined at the end of the six month measurement period by DHHS.

What is excluded?

Members with an intake appointment within 30 calendar days of the end of the six month measurement period.

How is the measure calculated?

DHHS will calculate the measure using the DHHS Community Mental Health Center Phoenix Encounter Data Reporting System.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

None.

EXPERIENCE.01 – Experience of Care Survey: Care Coordination Composite Score

Composite score of care coordination member survey measures for Medicaid patients in the IDN's attributed population age 18 and older.

The composite is made of the following questions:

- When you visited your personal doctor for a scheduled appointment, how often did he or she have your medical records or other information about your care?
- When your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results?
- How often did your personal doctor seem informed and up-to-date about the care you got from specialists?
- How often did you and your personal doctor talk about all the prescription medicines you were taking?
- How often did you get the help that you needed from your personal doctor's office to manage your care among different providers and services?

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed population who are 18 years of age or older.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for six months prior to the administering of the survey;
- Age will be determined as of the date of the sample for the survey is created; and
- Attributed population will be determined as of the date of the sample for the survey is created.

What is excluded?

Members in hospice.

How is the measure calculated?

DHHS will contract a survey vendor to field the survey and annual calculate the measure. DHHS's survey vendor will sample approximately 1,200 adults from each IDN with a goal of approximately 400 completed surveys for each IDN.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar years 2019 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

The Community Assessment of Healthcare Providers and Systems (CAHPS) is a trademark of the Agency for Healthcare Research and Quality. Detail on calculating measures for CAHPS is maintained by the National Committee for Quality Assurance of Health Plans. Please refer to HEDIS Volume 3 Technical Manual for granular details.

HOSP_ED.01 – Frequent Emergency Department Use in the Behavioral Health Population

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 6 and older who had 4 or more outpatient emergency department visits for any reason in the 12 months prior to the end of the measurement period.

A lower rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN health population age 6 and older (grouped by age 6-11, 12-17, 18-44, 45-64, 65+).

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire calendar year, with only one gap of up to 45 days allowable;
- Age is determined at the end of each measurement period; and
- Attributed population is determined at the end of each measurement period by DHHS.

What is excluded?

Members in hospice.

Visits that result in an admission to the hospital or a transfer to an acute care inpatient facility.

How is the measure calculated?

DHHS will calculate the measure semi-annually for the years 2018, 2019, and 2020 using claims, and encounter data. Emergency department visits will identify by type of bill, procedure, disposition, and revenue codes in institutional facility claims and encounter data. Where available, HEDIS definitions will be used to define an ED visit.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN's semi-annual performance in calendar year 2018 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

The measure was developed by DHHS as part of the DSRIP project.

HOSP_ED.02 – Selected Potentially Avoidable Emergency Department Visits

Rate of outpatient emergency department visits for selected potentially avoidable conditions per 1,000 Medicaid patients in the IDN's attributed population, age 6 or older that occur in the 12 months prior to the end of the measurement period.

Potentially avoidable conditions are emergency department visits for reasons that likely would have been more appropriately managed in an office setting (e.g. colds, rashes, joint and muscle pain, ear infections, etc., see table below for details). The measure does not represent all such conditions, nor does the measure assume that every ED visit was inappropriate. The measure does not include behavioral health diagnoses. The measure uses a selected list of conditions together to generally measure the degree to which patients in the population are seen in the right care setting.

A lower rate indicates better performance.

Who is the eligible population?

Medicaid members of the IDN's attributed population who are 6 years of age and older (grouped by age 6-11, 12-17, 18-44, 45-64, 65+).

Note:

- Age is determined at the end of each measurement period; and
- Attributed population is determined at the end of each measurement period by DHHS.

What is excluded?

Members in hospice.

Visits that result in an admission to the hospital or a transfer to an acute care inpatient facility.

How is the measure calculated?

DHHS will calculate the measure semi-annually for the years 2018, 2019, and 2020 using claims, and encounter data. Diagnosis of potentially avoidable conditions will be identified using ICD-10 codes in claims and encounter data. Emergency department visits will identify by type of bill, procedure, disposition, and revenue codes in institutional facility claims and encounter data. Where available, HEDIS definitions will be used to define an ED visit.

The measure is a weighted average of IDN attributed members comprised of 50% behavioral health population and 50% non-behavioral health population.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar year 2018 through 2020 will be used to determine performance-based incentive funding.

Statewide progress to meet goals in calendar years 2019 and 2020 will be used to evaluate statewide performance that may impact state funding.

What is the definition source of this measure?

The DHHS contract with the Medicaid Managed Care Organizations.

Selected Potentially Avoidable Diagnoses

| Code/Code Range | Description |
|--|---|
| A08.4 | Viral intestinal infection, unspecified |
| B08.4 | Enteroviral vesicular stomatitis with exanthem |
| B09 | Unspecified viral infection characterized by skin and mucous membrane lesions |
| B34.9 | Viral infection, unspecified |
| B86 | Scabies |
| G43.909 | Migraine, unspecified, not intractable, without status migrainosus |
| G44.1 | Vascular headache, not elsewhere classified |
| G93.3 | Postviral fatigue syndrome |
| H10.3 range | Unspecified acute conjunctivitis |
| H10.9 | Unspecified conjunctivitis |
| H60.0 range | Abscess of external ear |
| H60.31 range | Diffuse otitis externa |
| H60.32 range | Hemorrhagic otitis externa |
| H60.39 range | Other infective otitis externa |
| H61.2 range | Impacted cerumen |
| H65.0 range | Acute serous otitis media |
| H65.19 range | Other acute nonsuppurative otitis media |
| H65.9 range | Unspecified nonsuppurative otitis media |
| H66.9 range | Otitis media, unspecified |
| H92.0 range | Otalgia |
| J01.9 range | Acute sinusitis, unspecified |
| J02 range | Acute pharyngitis |
| J03 range | Acute tonsillitis |
| J06.9 | Acute upper respiratory infection, unspecified |
| J10.1 | Influenza due to other identified influenza virus with other respiratory manifestations |
| J20 range | Acute bronchitis |
| J32.9 | Chronic sinusitis, unspecified |
| J40 | Bronchitis, not specified as acute or chronic |
| J44.1 | Chronic obstructive pulmonary disease with (acute) exacerbation |
| J44.9 | Chronic obstructive pulmonary disease, unspecified |
| J45.2 range, excludes with status asthmaticus | Mild intermittent asthma |
| J45.3 range, excludes with status asthmaticus | Mild persistent asthma |
| J45.4 range, excludes with status asthmaticus | Moderate persistent asthma |
| J45.5 range, excludes with status asthmaticus | Severe persistent asthma |
| J45.90 range, excludes with status asthmaticus | Unspecified asthma |
| J45.998 | Other asthma |
| K52.9 | Noninfective gastroenteritis and colitis, unspecified |
| L20 range | Atopic dermatitis |
| L22 | Diaper dermatitis |
| L23.7 | Allergic contact dermatitis due to plants, except food |
| L23.9 | Allergic contact dermatitis, unspecified cause |
| L24.7 | Irritant contact dermatitis due to plants, except food |
| L24.9 | Irritant contact dermatitis, unspecified cause |
| L25.5 | Unspecified contact dermatitis due to plants, except food |
| L25.9 | Unspecified contact dermatitis, unspecified cause |
| L30.0 | Nummular dermatitis |
| L30.8 | Other specified dermatitis |

| Code/Code Range | Description |
|---|--|
| L30.9 | Dermatitis, unspecified |
| L50.9 | Urticaria, unspecified |
| M25.5 range, excludes M25.54 Pain in joints of hand range | Pain in joint |
| M54.2 | Cervicalgia |
| M54.5 | Low back pain |
| M54.89 | Other dorsalgia |
| M54.9 | Dorsalgia, unspecified |
| M60.8 range | Other myositis |
| M60.9 | Myositis, unspecified |
| M79.1 | Myalgia |
| M79.6 range | Pain in limb, hand, foot, fingers and toes |
| M79.7 | Fibromyalgia |
| N76.0 to .3 range | Vaginitis and vulvitis |
| R05 | Cough |
| R11.0 | Nausea |
| R11.10 | Vomiting, unspecified |
| R11.11 | Vomiting without nausea |
| R11.2 | Nausea with vomiting, unspecified |
| R19.7 | Diarrhea, unspecified |
| R20.9 | Unspecified disturbances of skin sensation |
| R21 | Rash and other nonspecific skin eruption |
| R30.0 | Dysuria |
| R42 | Dizziness and giddiness |
| R51 | Headache |
| R53.1 | Weakness |
| R53.2 | Functional quadriplegia |
| R53.81 | Other malaise |
| R53.83 | Other fatigue |
| R68.12 | Fussy infant (baby) |
| Z76.0 | Encounter for issue of repeat prescription |

HOSP_ED.03 – Follow-up After Emergency Department Visit for Mental Illness Within 30 Days

Percent of Medicaid patients in the IDN's attributed population, age 6 and older with an emergency department visits and a diagnosis of a mental health disorder during the first 11 months of the calendar year who had a follow up visit within 30 days of the visit.

A follow-up visit is an outpatient visit, an intensive outpatient encounter or a partial hospitalization for a mental health disorder.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 6 and older (grouped by age 6-17, 18 and older); and
- With a principal diagnosis of a mental health disorder resulting from an emergency department visit between January 1 and December 1 or July 1 to May 31 of the rolling year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) on the date of discharge through 30 calendar days after the date of discharge;
- Age is calculated as of the ED visit date;
- Attributed population will be determined as of the end of the measurement period by DHHS.

What is excluded?

Members:

- In hospice;
- With emergency department visits followed by admission to an inpatient (acute or non-acute) setting; or
- With multiple emergency department visits that occur within a 30 day period. Only the first emergency department visit is counted in the measure.

See Glossary for definition of inpatient and outpatient visits.

How is the measure calculated?

DHHS will calculate the measure for the years 2019 and 2020 using claims, and encounter data.

Diagnosis of mental health conditions will be identified using ICD-10 codes in claims and encounter data. Emergency department and follow-up visits will be identified by procedure codes in claims and encounter data.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar year 2019 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This HEDIS (FUM) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. FUM has two rates, only the 30 day rate is being used for DSRIP.

HOSP_ED.04 – Follow-up After Emergency Department Visit for Alcohol and other Drug Dependence within 30 Days

Percent of Medicaid patients in the IDN's attributed population age 13 and older with an emergency department visits and a principal diagnosis of substance use disorder during the first 11 months of the calendar year who had a follow up visit within 30 days of the visit.

A follow-up visit is an outpatient visit, an intensive outpatient encounter or a partial hospitalization for a substance use disorder.

A higher rate indicates better performance.

See Glossary for definition of outpatient visits.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 13 and older (grouped by age 13-17, 18 and older); and
- With a principal diagnosis of a mental health disorder resulting from an emergency department visit between January 1 and December 1 or July 1 to May 31 of the rolling year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) on the date of discharge through 30 calendar days after the date of discharge;
- Age is calculated as of the ED visit date;
- Attributed population will be determined as of the end of the measurement period by DHHS.

What is excluded?

Members:

- In hospice;
- With emergency department visits followed by admission to an inpatient (acute or non-acute) setting; or
- With multiple emergency department visits that occur within a 30 day period. Only the first emergency department visit is counted in the measure.

See Glossary for definition of inpatient and outpatient visits.

How is the measure calculated?

DHHS will calculate the measure for the years 2019 and 2020 using claims, and encounter data. Diagnosis of AOD will be identified using ICD-10 codes in claims and encounter data. Emergency department and follow-up visits will be identified by procedure codes in claims and encounter data.

The measure will be calculated semi-annually looking at overlapping 12 month periods.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN semi-annual performance in calendar year 2019 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This HEDIS (FUA) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. FUA has two rates, only the 30 day rate is being used for DSRIP.

HOSP_INP.01 – Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days.

Percent of inpatient hospital discharges in the first 11 months of a rolling measurement year of Medicaid patients in the IDN's attributed behavioral health population, age 18 years of age and older, whose inpatient stay was followed by an unplanned acute inpatient readmission of any diagnosis within 30 days. The measure will be calculated at six month intervals (e.g., 7/1/18 to 6/1/19 and 1/1/19 to 12/1/19).

Unplanned readmissions include readmissions that are not scheduled such as appendectomy.

A lower rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN behavioral health population:

- Age 18 and older; and
- With an acute inpatient discharge from an acute inpatient stay (including NH Hospital) on or between July 1 and June 1 or January 1 and December 1 of the rolling measurement year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) 180 days prior and 30 calendar days after the discharge. One gap of up to 45 days allowable for the 180 day period prior to the discharge and no gap during the 30 days after the discharge;
- Age is calculated as of the discharge date;
- Attributed behavioral health population will be determined as of the end of the measurement period by DHHS; and
- See Glossary for definition of acute inpatient visits.

What is excluded?

Members:

- In hospice;
- Who died during the inpatient stay;
- With inpatient stays for maternity, cancer, rehabilitation, potentially planned procedures, and/or transplant; or
- With readmissions that occur on the same calendar day of the discharge.

How is the measure calculated?

DHHS will calculate the measure for calendar years 2019 and 2020 using claims, encounter data, and NH Hospital discharges for otherwise enrolled Medicaid members where admission falls under the institute of mental diseases exclusion for payment. Inpatient stays will be identified by procedure codes in claims and encounter data. Diagnosis codes for maternity, cancer, rehabilitation, transplant and planned procedures will be identified using ICD-10 codes in claims and encounter data.

Note: DHHS will be exploring the most feasible approach for standardizing rates for age and severity across the IDNs.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

Statewide progress to meet goals in calendar years 2019 and 2020 will be used to evaluate statewide performance that may impact state funding.

What is the definition source of this measure?

This HEDIS (PCR) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Note that the measure is modified to include discharges from an institute of mental disease such as New Hampshire Hospital for members 22-64 years of age, has reduced continuous enrollment requirement and is calculated semi-annually involving a rolling measurement year

HOSP_INP.02 – Timely Transmission of Transitional Record After Hospital Discharge

Percent of discharges at the IDN's Partner Hospitals and Nursing Facilities for Medicaid patients of any age to a home or any other site of care during the calendar year, for which a complete transition record was transmitted to the provider (acute or non-acute facility, primary physician, or other health care professional) designated for follow-up care within 24 hours of discharge.

The intent of the measure is to capture whether the inpatient facility sent a transition record including all required elements. Receipt of the transition record by the provider designated for follow-up care is not required. A record may be transmitted via secure fax, secure e-mail, or mutual access to an electronic health record system. The time and method of transmission should be documented to assess whether transmission was timely.

A complete transition record is a set of data elements related to enrollee's diagnosis, treatment, and care plan that is discussed with and provided to the enrollee in a printed or electronic format at each transition of care. The record should include:

- Inpatient care;
- Post discharge/patient self-management;
- Advance care plan;
- Contact information/plan for follow-up care; and
- Discharge information.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members with a discharge from an IDN's partner hospital or nursing facility to another site of care. Partner hospital discharges to New Hampshire Hospital are included in this measure. However, discharges from NH Hospital are not included.

Note:

- Member must be enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) on the date of discharge.

What is excluded?

Members who:

- Died during the inpatient stay; and
- Member who left against advice or discontinued care.

Discharges from non-IDN partner hospitals and nursing facilities and NH Hospital discharges are excluded.

How is the measure calculated?

This measure will be calculated for calendar years 2018, 2019, and 2020 jointly by DHHS and the IDNs using claims and encounter data, and electronic health record system data. DHHS will provide the IDNs a sample of Medicaid members who were discharged from facilities within the IDN. The IDN will verify that a completed transition record was transmitted for each member and will share that information with DHHS.

Discharges will be identified by type of bill, revenue code and discharge status using claims and encounter data.

What is the IDN's responsibility for calculating this measure?

IDN's will be required to verify and report that a completed transition record was transmitted for each member included in the DHHS sample.

How does this outcome metric impact payment?

IDN's ability to support reporting for the measure in 2018 will be used to determine performance-based incentive funding.

IDN annual performance in calendar years 2019 and 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This measure is maintained by the American Medical Association's convened Physician Consortium for Performance Measurement and endorsed by the National Quality Forum (NQF 0648).

HOSP_INP.03 – Follow-up After Hospitalization for Mental Illness Within 7 Days

Percent of inpatient hospital discharges in the first 11 months of a rolling measurement year of Medicaid patients in the IDN's attributed population, age 6 and older who were hospitalized for the treatment of mental disorders and had a follow-up visit by a mental health provider within 7 days after their discharge from the hospital. The measure will be calculated at six month intervals (e.g., 7/1/18 to 6/1/19 and 1/1/19 to 12/1/19).

Mental health provider is defined as:

- MD or doctor of osteopathy who is certifies as a psychiatrist or a child psychiatrist;
- Licensed psychologist;
- Certified clinical social worker;
- Certified psychiatric nurse; or clinical nurse specialist;
- Certified counselor practicing as a marital and family therapist; or
- Provider working at a Community Mental Health Center.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 6 and older;
- With a discharge from an acute inpatient stay (including NH Hospital) on or between July 1 and June 1 or January 1 and December 1 of the rolling year; and
- With a principal diagnosis of mental illness resulting from the inpatient stay referenced above.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) on the date of discharge through 30 calendar days after the date of discharge;
- Age is calculated as of the date of discharge;
- Attributed population will be determined as of the end of the measurement period; and
- See Glossary for definition of acute inpatient visits.

What is excluded?

Members:

- In hospice;
- Discharged from non-acute inpatient stays; or
- Discharged followed by a readmission or direct transfer to an inpatient stay that occurs within 30 days of the discharge.

How is the measure calculated?

DHHS will calculate the measure for the years 2018, 2019, and 2020 using claims, encounter, and NH Hospital data. Diagnosis of mental health condition will be identified using ICD-10 codes in claims, encounter, and NH Hospital data. Follow-up visits will be identified by procedure codes in claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar year 2018 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This HEDIS (FUH) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Note that the measure is modified to be calculated semi-annually and to include discharges from an institute of mental disease such as New Hampshire Hospital for members 22-64 years of age. Additionally, Community Mental Health Center visits for HEDIS listed procedure codes are included in the numerator even if the individual performing provider is not identified on the claim.

HOSP_INP.04 – Follow-up After Hospitalization for Mental Illness Within 30 Days

Percent of inpatient hospital discharges in the first 11 months of a rolling measurement year of Medicaid patients in the IDN's attributed population, age 6 and older who were hospitalized for the treatment of mental disorders and had a follow-up visit by a mental health provider within 30 days after their discharge from the hospital. The measure will be calculated at six month intervals (e.g., 7/1/18 to 6/1/19 and 1/1/19 to 12/1/19).

Note: follow-up visits that qualify under the HOSP_INP.03 Follow-up Within 7 Days measure also count for the 30 day measure.

Mental health provider is defined as:

- MD or doctor of osteopathy who is certifies as a psychiatrist or a child psychiatrist;
- Licensed psychologist;
- Certified clinical social worker;
- Certified psychiatric nurse; or clinical nurse specialist;
- Certified counselor practicing as a marital and family therapist; or
- Provider working at a Community Mental Health Center.

A higher rate indicates better performance.

Who is the eligible population?

Medicaid members in the attributed IDN population:

- Age 6 and older;
- With a discharge from an acute inpatient stay (including NH Hospital) on or between July 1 and June 1 or January 1 and December 1 of the rolling year; and
- With a principal diagnosis of mental illness resulting from the inpatient stay referenced above.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) on the date of discharge through 30 calendar days after the date of discharge;
- Age is calculated as of the date of discharge;
- Attributed population will be determined as of the end of the measurement period; and
- See Glossary for definition of acute inpatient visits.

What is excluded?

Members:

- In hospice;
- Discharged from non-acute inpatient stays; or
- Discharged followed by a readmission or direct transfer to an inpatient stay that occurs within 30 days of the discharge.

How is the measure calculated?

DHHS will calculate the measure for the years 2018, 2019, and 2020 using claims, encounter, and NH Hospital data. Diagnosis of mental health condition will be identified using ICD-10 codes in claims, encounter, and NH Hospital data. Follow-up visits will be identified by procedure codes in claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar year 2018 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This HEDIS (FUH) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Note that the measure is modified to be calculated semi-annually and to include discharges from an institute of mental disease such as New Hampshire Hospital for members 22-64 years of age. Additionally, Community Mental Health Center visits for HEDIS listed procedure codes are included in the numerator even if the individual performing provider is not identified on the claim.

OPIODRX.01 – Extended Daily Dosage of Opioids Greater than 120mg Morphine Equivalent Dose

Rate of Medicaid patients receiving opioids for 15 days or more at a high dose per 1,000 members in the IDN's attributed population, age 18 and older, who received two or more prescriptions for opioids during a rolling year. The measure will be calculated at six month intervals (e.g., 7/1/18 to 6/1/19 and 1/1/19 to 12/1/19).

A high dose is determined by calculating each prescription's morphine equivalent dose (MED), which is a standard unit that determines a patient's cumulative intake of all prescribed opioid drugs over 24 hours. An MED greater than 120 mg is considered a high dose.

Each member's prescribed opioid dosage is evaluated for each day covered by a prescription. Days where the total opioid dosage MED rate exceeds 120 mg is considered a high dose day.

A lower rate indicates better performance.

Who is the eligible population?

Medicaid members in the IDN's attributed population:

- Age 18 and older; and
- With at least two opioid medications during the calendar year.

Note:

- Member must be continuously enrolled in Medicaid (regardless of whether care is delivered through a Medicaid Managed Care plan, a Premium Assistance Program private health plan, or through Medicaid Fee for Service) for the entire measurement period. No gaps in enrollment are allowed;
- Age and will be determined as of the beginning of the measurement period; and
- Attributed population will be determined as of the end of the measurement period.

What is excluded?

Members:

- In hospice; or
- With cancer and/or sickle cell disease during the measurement period.

How is the measure calculated?

DHHS will calculate the measure for calendar years 2018, 2019, and 2020 using claims, and encounter data. Opioid prescriptions will be identified by National Drug Codes in pharmacy claims and encounter data. Diagnosis of cancer or sickle cell disease will be identified using ICD-10 codes in claims and encounter data.

What is the IDN's responsibility for calculating this measure?

None.

How does this outcome metric impact payment?

IDN annual performance in calendar year 2018 through 2020 will be used to determine performance-based incentive funding.

What is the definition source of this measure?

This HEDIS (UOD) measure is maintained by the National Committee for Quality Assurance of Health Plans (NCQA). Please refer to *HEDIS Volume 2 Technical Specifications for Health Plan* for granular details and detailed specifications on this measure. Note that the measure is modified to be calculated semi-annually.

Appendix A: Integrated Delivery Network Detailed Measure Reporting Specifications

The DSRIP Program Detailed Measure Reporting Specifications is a detailed manual providing the Independent Delivery Networks (IDN) the necessary information to report performance measures to DHHS. The manual will be updated periodically to reflect changes in the DSRIP program and provide further clarity as needed.

ASSESS_SCREEN.01 - Use of Comprehensive Core Standardized Assessment by the IDN's Medicaid Billing Providers

Identifier:

ASSESS_SCREEN.01

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of patients seen by the IDN's Medicaid billing providers during the previous 12-months for a visit, who had a completed Comprehensive Core Standardized Assessment by the most recent visit during the measure reporting period as indicated in the patient's electronic health record (EHR) or other electronic tracking system. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid* patient 12 years and older** with a visit to an IDN Medicaid Billing Provider. The visit must have:

- Occurred in the measure data reporting period;
- Occurred in an office or other community-based setting (excluding acute and non-acute inpatient settings such as hospitals and nursing homes);
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

**Patient's age determined as of the date of the last visit to an IDN Medicaid Billing Provider.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Unit of Analysis:

Percent of patients.

Definitions Specific to Measure:

Comprehensive Core Assessment – The assessment documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Office and Community Based Settings – Use Place of Service Codes 03 – School, 04- Homeless Shelter, 11 – Office, 12-Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

Exclusions:

Patients with only Inpatient and Emergency Department Hospital visits during the reporting period.

Data Source/Type:

Administrative Data: Electronic Health records

Contract Reference:

CMS NH DSRIP Protocols C and D

Measure Submission Frequency:

Semi-annually with overlapping 12 month look back (except for 7/1/17 to 12/31/17 pilot where both numerator and denominator will be a 6 month period).

Data Source Life Span:

2017-07-01 - 2020-12-31

Measure Data Source Time Period:

6 months for denominator, 12 months for numerator

Measure Data Source Period Preview:

Submission #1: 2017-07-01 - 2017-12-31

Submission #2: 2017-07-01 - 2018-06-30

Submission #3: 2018-01-01 - 2018-12-31

Submission #4: 2018-07-01 - 2019-06-30

Submission #5: 2019-01-01 - 2019-12-31

Submission #6: 2019-07-01 - 2020-06-30

Submission #7: 2020-01-01 - 2020-12-31

Submission Due Date Lag Period:

3 months.

Measure Due Date Previews:

Submission #1: 2018-04-01

Submission #2: 2018-10-01

Submission #3: 2019-04-01

Submission #4: 2019-10-01

Submission #5: 2020-04-01

Submission #6: 2020-10-01

Submission #7: 2021-04-01

ASSESS_SCREEN.01 – Data Element Specifications

Identifier:

ASSESS_SCREEN.01-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

Members in the eligible population whose electronic health record (EHR) or other electronic tracking system shows evidence of a completed Comprehensive Core Assessment within the past 12 months of the most recent visit during the measure reporting period with the IDN's Medicaid Billing Provider.

The most recent visit must have:

- Occurred in the measure data reporting period;
- Occurred in an office or other community-based setting excluding acute and non-acute inpatient settings;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.01-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.01-RATE

Class:

Rate

Type:

Numeric

Technical Definition:

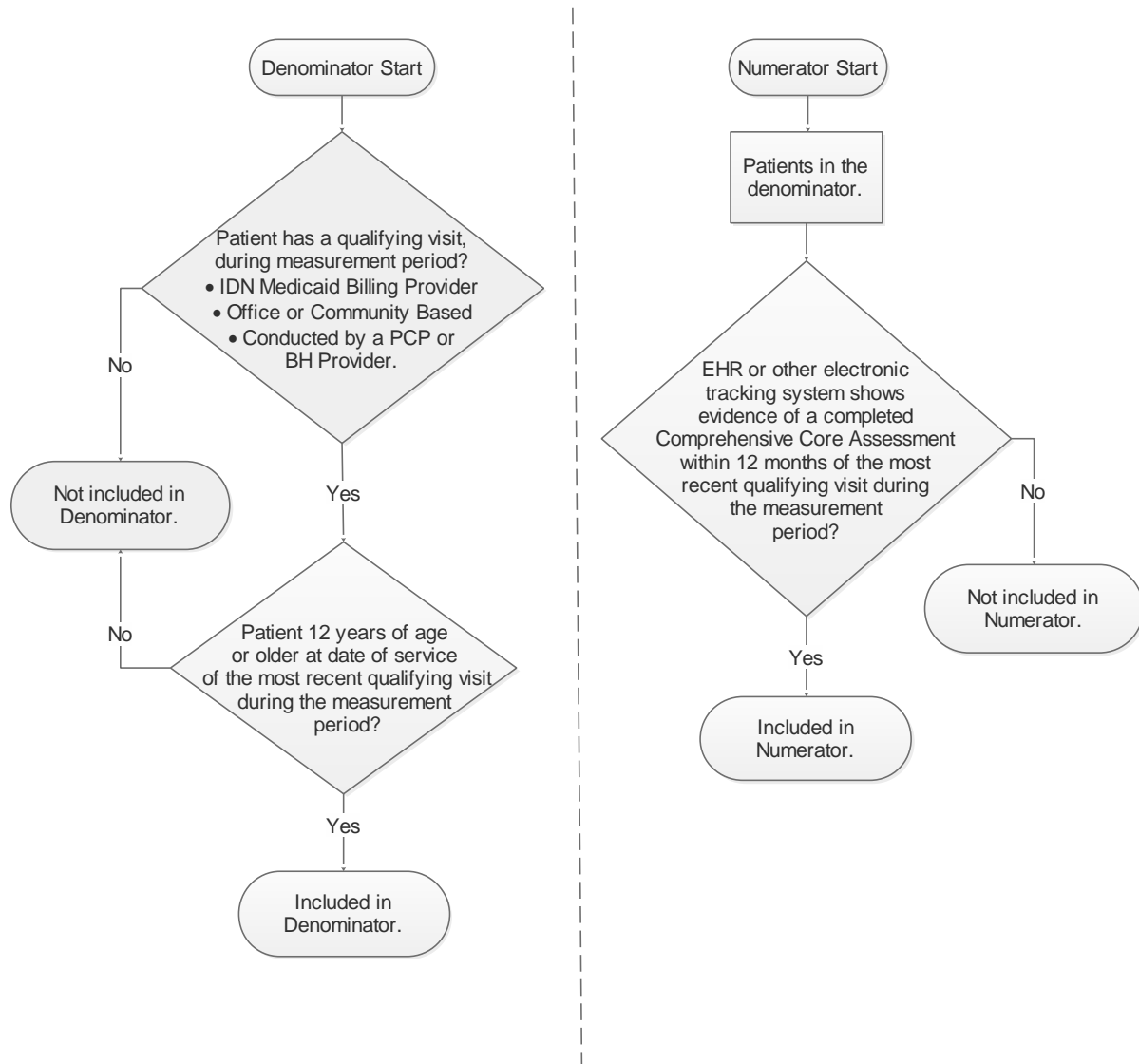
Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00 ; Must be ≤ 100.00

Measure Flow:

Individual Measure Flow Chart: ASSESS_SCREEN.01
Use of Comprehensive Core Standardized Assessment By the IDN's Medicaid Billing Providers



ASSESS_SCREEN.02 - Appropriate Follow-Up Plan for Positive Screenings for Potential Depression and/or Substance Use Disorder by the IDN's Medicaid Billing Providers

Identifier:

ASSESS_SCREEN.02

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of positive screenings for potential substance use disorder and/or depression for patients seen at the IDN's Medicaid Billing providers with appropriate follow-up plan in place* as documented in the patient's electronic health record (EHR) or other electronic tracking system as of the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

*The measure is only assessing whether follow-up plan is in place, not that the follow-up plan has been implemented.

Eligible Population:

Any NH Medicaid patient* age 12 years and older**, who during a visit at the IDN's Medicaid billing provider:

- Received a substance use disorder and/or depression screening; and
- Received a positive screening for depression and/or substance use disorder.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Patient's age determined as of the date of the last visit at the IDN's Medicaid billing provider.

The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office or other community-based setting (excluding acute and non-acute inpatient settings such as hospitals and nursing homes);
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Unit of Analysis:

Percent of Screenings.

Technical Definition:

This measure is a parent measure that groups together related submeasures. Data is submitted only for submeasures. After submission of submeasure data DHHS calculates the parent measure by totaling together the submitted submeasures. Each submeasure has its own measure and data element technical specifications detail. The information below provides a general technical description of the measure as a whole.

Definitions Specific to Measure:

Screenings – Tools used for this measure should be a part of the comprehensive core assessment documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Positive Screenings – Screening results that indicate a member is potentially at risk of developing or of having depression or substance use disorder as documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Office and Community Based Visit – Use Place of Service Codes 03 – School, 04- Homeless Shelter, 11 – Office, 12-Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

Appropriate Follow-up Plan – Documented plan following the requirements documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Exclusions:

A patient is not eligible if one or more of the following conditions are documented:

1. Patient refuses to participate in the follow-up plan;
2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status;
3. Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools. For example: certain court appointed cases or cases of delirium; or
4. Any other exclusion documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare...

Data Source/Type:

Administrative Data: Electronic Health records

Contract Reference:

CMS NH DSRIP Protocols C and D

Measure Submission Frequency: Semi-annually.

Data Source Life Span:

2017-07-01 - 2020-12-31

Measure Data Source Time Period:

6 months.

Measure Data Source Period Preview:

Submission #1: 2017-07-01 - 2017-12-31

Submission #2: 2018-01-01 - 2018-06-30

Submission #3: 2018-07-01 - 2018-12-31

Submission #4: 2019-01-01 - 2019-06-30

Submission #5: 2019-07-01 - 2019-12-31

Submission #6: 2020-01-01 - 2020-06-30

Submission #7: 2020-07-01 - 2020-12-31

Submission Due Date Lag Period:

3 months.

Measure Due Date Previews:

Submission #1: 2018-04-01

Submission #2: 2018-10-01

Submission #3: 2019-04-01

Submission #4: 2019-10-01

Submission #5: 2020-04-01

Submission #6: 2020-10-01

Submission #7: 2021-04-01

ASSESS_SCREEN.02-A: Depression

Identifier:

ASSESS_SCREEN.02-A

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of positive screenings for potential depression for patients seen at the IDN's Medicaid Billing providers with appropriate follow-up plan in place* as documented in the patient's electronic health record (EHR) or other electronic tracking system on the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

*The measure is only assessing whether follow-up plan is in place, not that the follow-up plan has been implemented.

Eligible Population:

Any NH Medicaid patient* age 12 years and older**, who during a visit at the IDN's Medicaid billing provider:

- Received a depression screening; and
- Received a positive screening for depression.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Patient's age determined as of the date of the last visit at the IDN's Medicaid billing provider. The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office or other community-based setting (excluding acute and non-acute inpatient settings such as hospitals and nursing homes);
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Screenings – Tools used for this measure should be a part of the comprehensive core assessment documented in the IDN's approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Positive Screenings – Screening results that indicate a member is at risk of developing or having depression documented in the IDN's approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Office and Community Based Visit – Use Place of Service Codes 03 – School, 04- Homeless Shelter, 11 – Office, 12-Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

Appropriate Follow-up Plan – Documented plan following the requirements described in the DSRIP Core Competency Project: B1 Integrated Healthcare.

Exclusions:

A patient is not eligible if one or more of the following conditions are documented:

1. Patient refuses to participate in the follow-up plan
2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
3. Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools. For example: certain court appointed cases or cases of delirium; or
4. Any other exclusion documented in the IDN's approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Data Source/Type:

Administrative Data: Electronic Health records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.02-A – Data Element Specifications

Identifier:

ASSESS_SCREEN.02-A-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of screenings in the denominator that have a follow-up plan in place for depression documented in the patient's electronic health record (EHR) or other electronic tracking system on the date of the positive screening.

Note: The numerator is only assessing whether follow-up plan is in place, not that the follow-up plan has been implemented.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.02-A-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The number of positive screenings occurring in the Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.02-A-RATE

Class:

Rate

Type:

Numeric

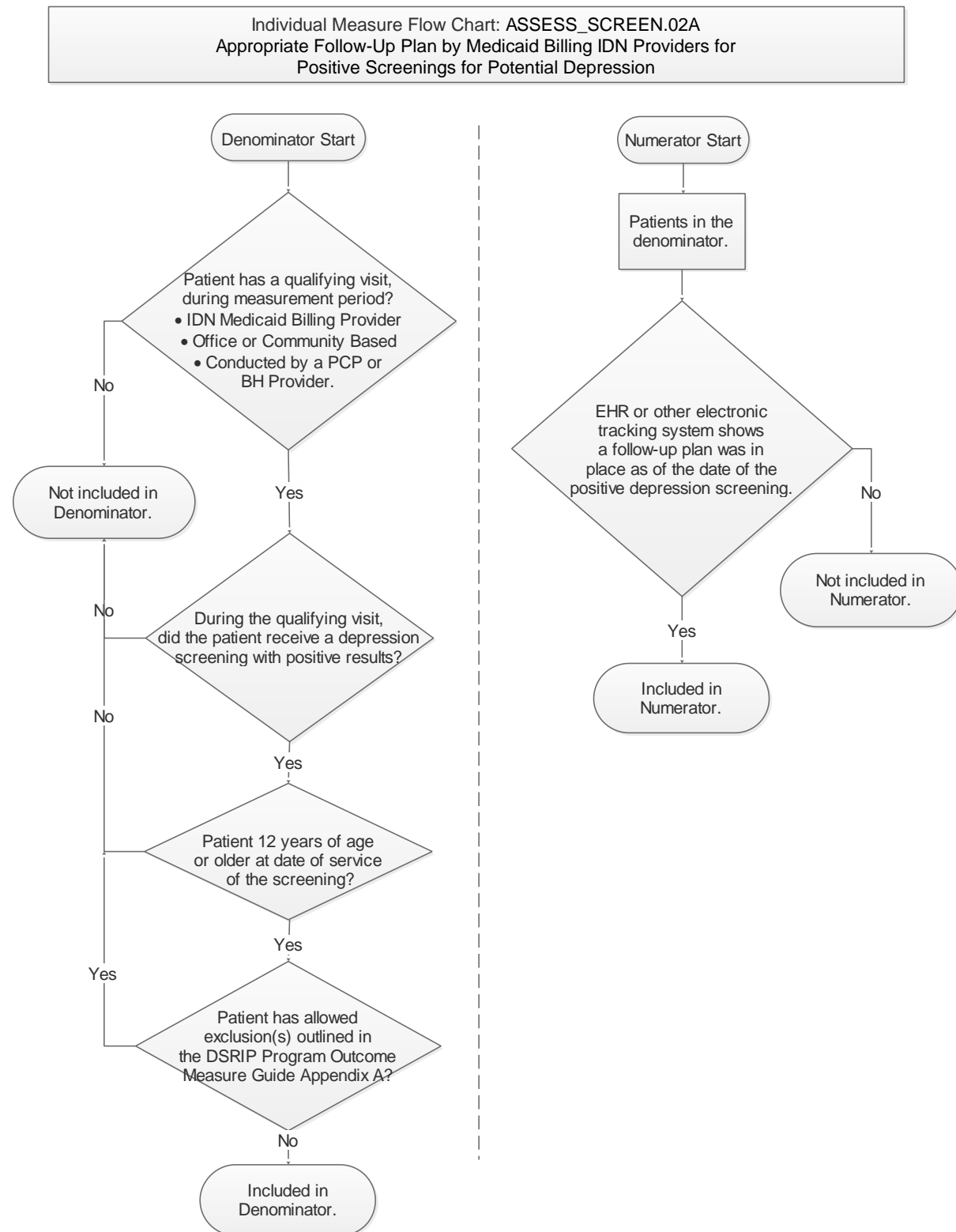
Technical Definition:

Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:



ASSESS_SCREEN.02-B: Substance Use Disorder

Identifier:

ASSESS_SCREEN.02-B

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of positive screenings for potential substance use disorder for patients seen at the IDN's Medicaid Billing providers with appropriate follow-up plan in place* as documented in the patient's electronic health record (EHR) or other electronic tracking system as of the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

*The measure is only assessing whether follow-up plan is in place, not that the follow-up plan has been implemented.

Eligible Population:

Any NH Medicaid patient* age 12 years and older**, who during a visit at the IDN's Medicaid billing provider:

- Received a substance use disorder screening; and
- Received a positive screening for substance use disorder.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Patient's age determined as of the date of the last visit at the IDN's Medicaid billing provider.

The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
 - Occurred in an office or other community-based setting excluding acute and non-acute inpatient settings;
 - Been for a NH Medicaid billable service: and
 - Been conducted by a provider at a primary care practice, or behavioral health provider.
-

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Screenings – Tools used for this measure should be a part of the comprehensive core assessment documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Positive Screenings – Screening results that indicate a member is at risk of developing or having depression or substance use disorder as documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Office and Community Based Visit – Use Place of Service Codes 03 – School, 04- Homeless Shelter, 11 – Office, 12-Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

Appropriate Follow-up Plan – Documented plan following the requirements documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Exclusions:

A patient is not eligible if one or more of the following conditions are documented:

1. Patient refuses to participate in the follow-up plan;
2. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status;
3. Situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools. For example: certain court appointed cases or cases of delirium; or
4. Any other exclusion documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.02-B – Data Element Specifications

Identifier:

ASSESS_SCREEN.02-B-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of screenings in the denominator that have a follow-up plan in place for substance use disorder documented in the patient's electronic health record (EHR) or other electronic tracking system on the date of the positive screening.

Note: The numerator is only assessing whether follow-up plan is in place, not that the follow-up plan has been implemented.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.02-B-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The number of positive screenings occurring in the Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.02-B-RATE

Class:

Rate

Type:

Numeric

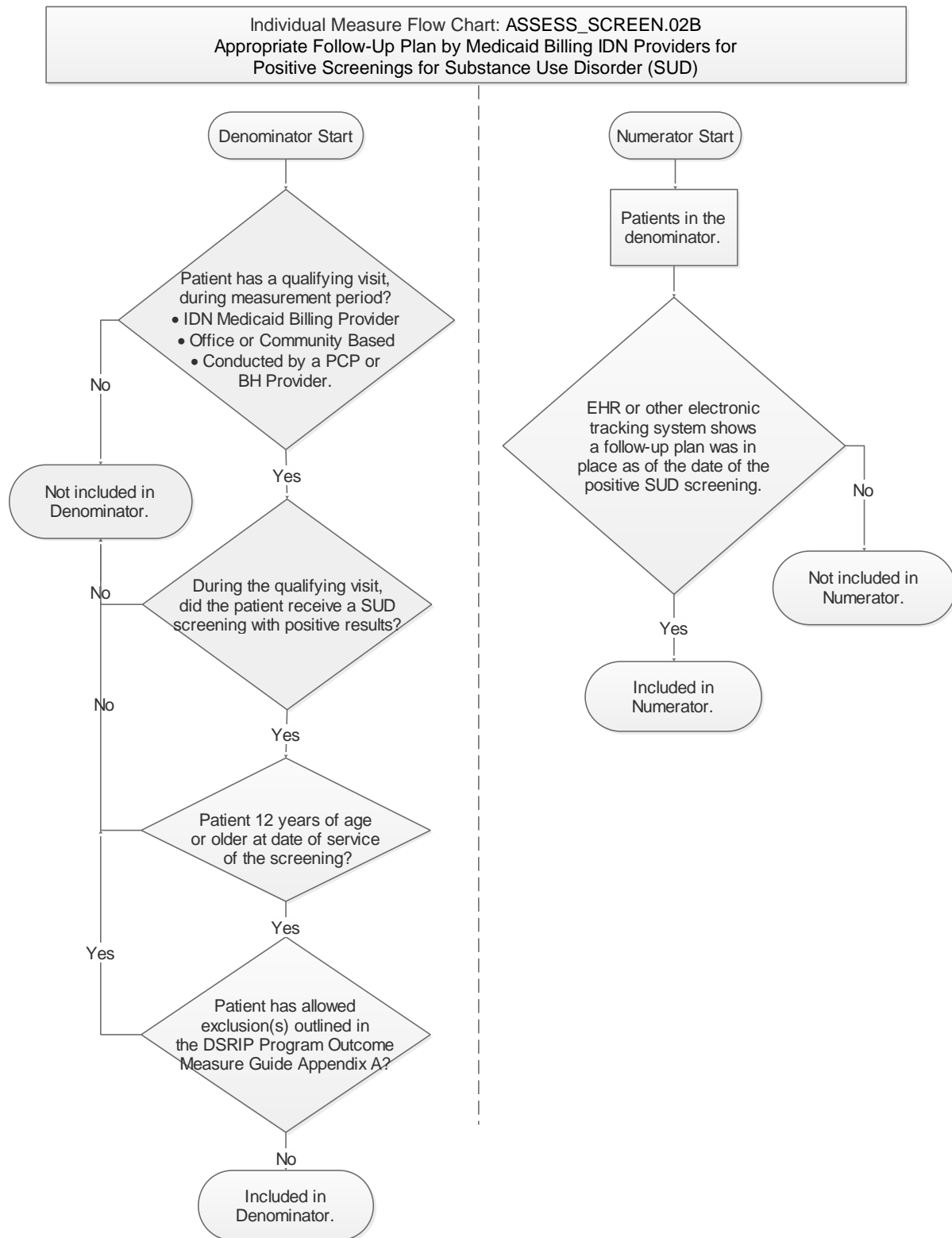
Technical Definition:

Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:



ASSESS_SCREEN.03 - Selected U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by the IDN's Medicaid Billing Providers

Identifier:

ASSESS_SCREEN.03

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of IDN's attributed behavioral health patients seen at the IDN's Medicaid Billing providers where the patient's electronic health record (EHR) or other electronic tracking system contains evidence of selected recommended USPSTF A&B Services.

See each submeasure for unique measure descriptions.

Eligible Population:

In general, any NH Medicaid patient* age 6 years and older in the IDN's attributed behavioral health population group** with an office visit during the measurement period at the IDN's Medicaid Billing providers.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

**Attributed behavioral health population is determined at the end of the reporting period by DHHS. Patients do not have to be continuously enrolled in NH Medicaid for the reporting period.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

See each submeasure for unique eligible population details.

Technical Definition:

This measure is a parent measure that groups together related submeasures. Data is submitted only for submeasures. After submission of submeasure data DHHS calculates the parent measure by totaling the sum of numerators and denominators.

Each submeasure has its own measure and data element technical specifications detail. The information below provides a general technical description of the measure as a whole.

Unit of Analysis:

Percent of Patients.

Definitions Specific to Measure:

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

Measure Submission Frequency: Annually.

Data Source Life Span:

2018-01-01 - 2020-12-31

Measure Data Source Time Period:

12 months.

Measure Data Source Period Preview:

Submission #1: 2018-01-01 - 2018-12-31

Submission #2: 2019-01-01 - 2019-12-31

Submission #3: 2020-01-01 - 2020-12-31

Submission Due Date Lag Period:

7 months.

Measure Due Date Previews:

Submission #1: 2019-08-01

Submission #2: 2020-08-01

Submission #3: 2021-08-01

ASSESS_SCREEN.03-A: Intimate Partner Violence and Applicable Referrals

Identifier:

ASSESS_SCREEN.03-A

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 18 through 49 seen by the IDN's primary care or behavioral health provider for a well care visit during the calendar year, who are screened for intimate partner violence and provided interventions for positive results, as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid female patient* age 18 through 49, in the IDN's attributed behavioral health population group** with a well care visit during the measurement period at the IDN's Medicaid Billing providers.

Patient's age is determined as of the end of the most recent office visit during the measurement period.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

**Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the well care visit. Patients do not have to be continuously enrolled in NH Medicaid for the reporting period. The well visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Attributed Behavioral Health Population – Because IDN's do not have all the data needed to determine whether a patient is included in the behavioral health population for this measure, DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee five months after the end of each measure data source time period. The IDN will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for this measure. Specifics of DHHS's method for assigning the behavioral health indicator are included in the NH DSRIP Outcome Measure Specifications.

Clinical Summary –

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/high-blood-pressure-in-adults-screening>

Interventions – May include counseling, home visits, information cards, referrals to community services and mentoring services.

Intimate partner violence – includes physical, sexual, or psychological harm by a current or former partner or spouse.

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 – Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic

Screening tool – Evidenced-based Screening tools that identify IPV include (not a complete list): Hurt, Insult, Threaten, Scream (HITS); Ongoing Abuse Screen/Ongoing Violence Assessment (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire-Short Form (CTQ-SF); and Women Abuse Screen Tool (WAST); Partner Violence Screen (PVS); and Abuse Assessment Screen (AAS)

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-A – Data Element Specifications Intimate Partner Violence and Applicable Referrals

Identifier:

ASSESS_SCREEN.03-A-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of females age 18 through 49 Medicaid patients in the eligible population who are screened for intimate partner violence during the well visit with interventions provided for positive results, as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit.

The well care visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.03-A-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The eligible population

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-A-RATE

Class:

Rate

Type:

Numeric

Technical Definition:

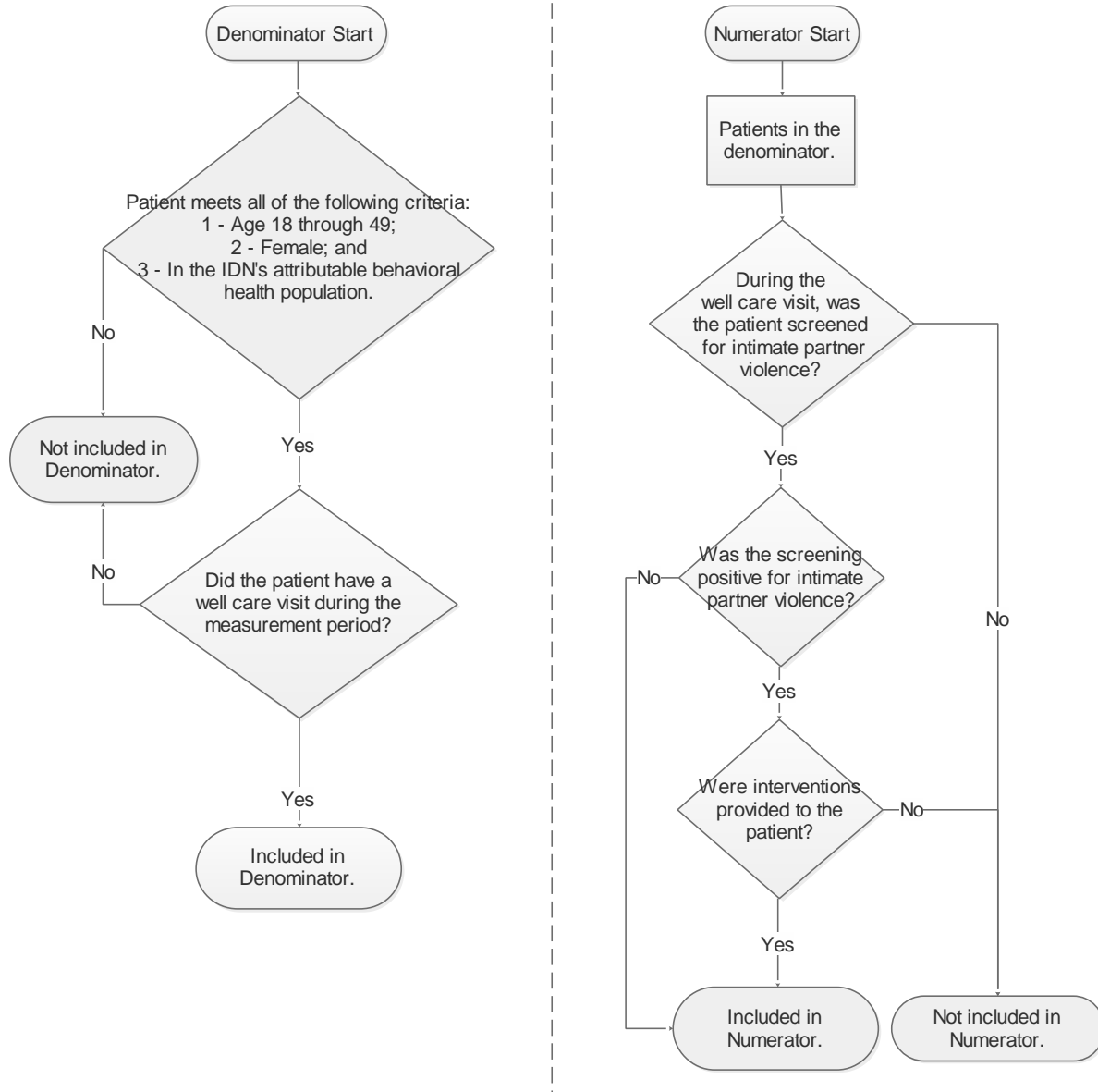
Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:

Individual Measure Flow Chart: ASSESS_SCREEN.03A
USPSTF A&B Services for BH Population
Intimate Partner Violence Screening



ASSESS_SCREEN.03-B: Blood Pressure Screening

Identifier:

ASSESS_SCREEN.03-B

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 18 and older seen by the IDN's primary care or behavioral health provider for an office visit during the calendar year, who have a current blood pressure screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met. Patients seen only at behavioral health providers who do not routinely do blood pressure screenings must still be reported in the denominator.

Eligible Population:

Any NH Medicaid patient* age 18 and older in the IDN's attributed behavioral health population group** with an office visit during the measurement period at the IDN's Medicaid Billing providers. Patient's age is determined as of the end of the most recent office visit during the measurement period.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the most recent visit. The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Clinical Summary –

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/high-blood-pressure-in-adults-screening>

Current Blood Pressure –

- Age 18-39 once every 3 years.
- Age 40 years or older annually.

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic.

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-B – Data Element Specifications Blood Pressure Screening

Identifier:

ASSESS_SCREEN.03-B-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of behavioral health Medicaid patients 18 and older in the IDN's attributed eligible population with a current blood pressure screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the most recent visit.

The most recent visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Current blood pressure screening is:

- Age 18-39 once every 3 years; or
 - Age 40 years or older annually.
-

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.03-B-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-B-RATE

Class:

Rate

Type:

Numeric

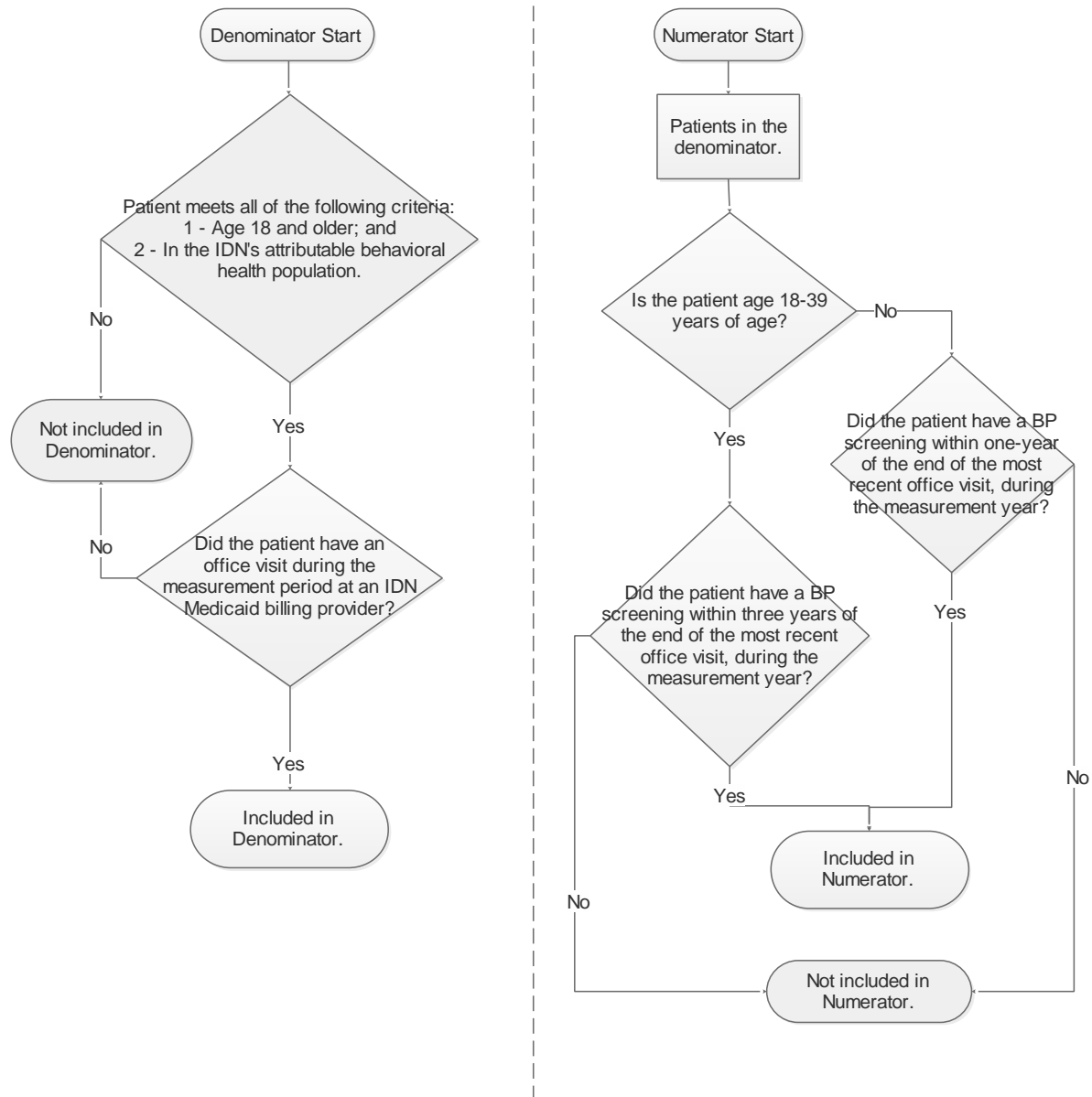
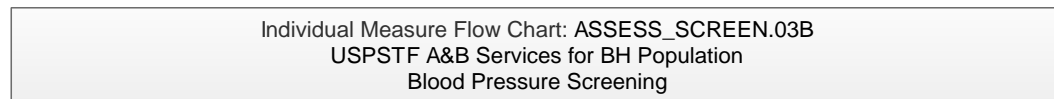
Technical Definition:

Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:



ASSESS_SCREEN.03-C: Adult Lipid Screenings

Identifier:

ASSESS_SCREEN.03-C

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 45 and older (females 55 and older) seen by the IDN's primary care or behavioral health provider for an office visit during the measurement period who have a current lipid screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met. Patients seen only at behavioral health providers who do not routinely do lipid screenings must still be reported in the denominator.

Eligible Population:

Any NH Medicaid patient* age 45 and older (females 55 and older) in the IDN's attributed behavioral health population group** with an office visit during the measurement period at the IDN's Medicaid Billing providers. Patient's age is determined as of the end of the most recent office visit during the measurement period.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the most recent visit. The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:**Current Lipid Screening** –

- Males age 45 through 65 once every 2 years;
- Females age 55 through 65 once every 2 years; and
- Age 65 and older annually.

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-C – Data Element Specifications BH Adult Males Age 18-49

Identifier:

ASSESS_SCREEN.03-C-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of Medicaid patients in the IDN's attributed behavioral health patients age 45 and older (females 55 and older) in the eligible population who have a current lipid screening as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit.

The most recent visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Current Lipid Screening:

- Males age 45 through 65 once every 2 years;
 - Females age 55 through 65 once every 2 years; and
 - Age 65 and older annually.
-

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.03-C-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-C-RATE

Class:

Rate

Type:

Numeric

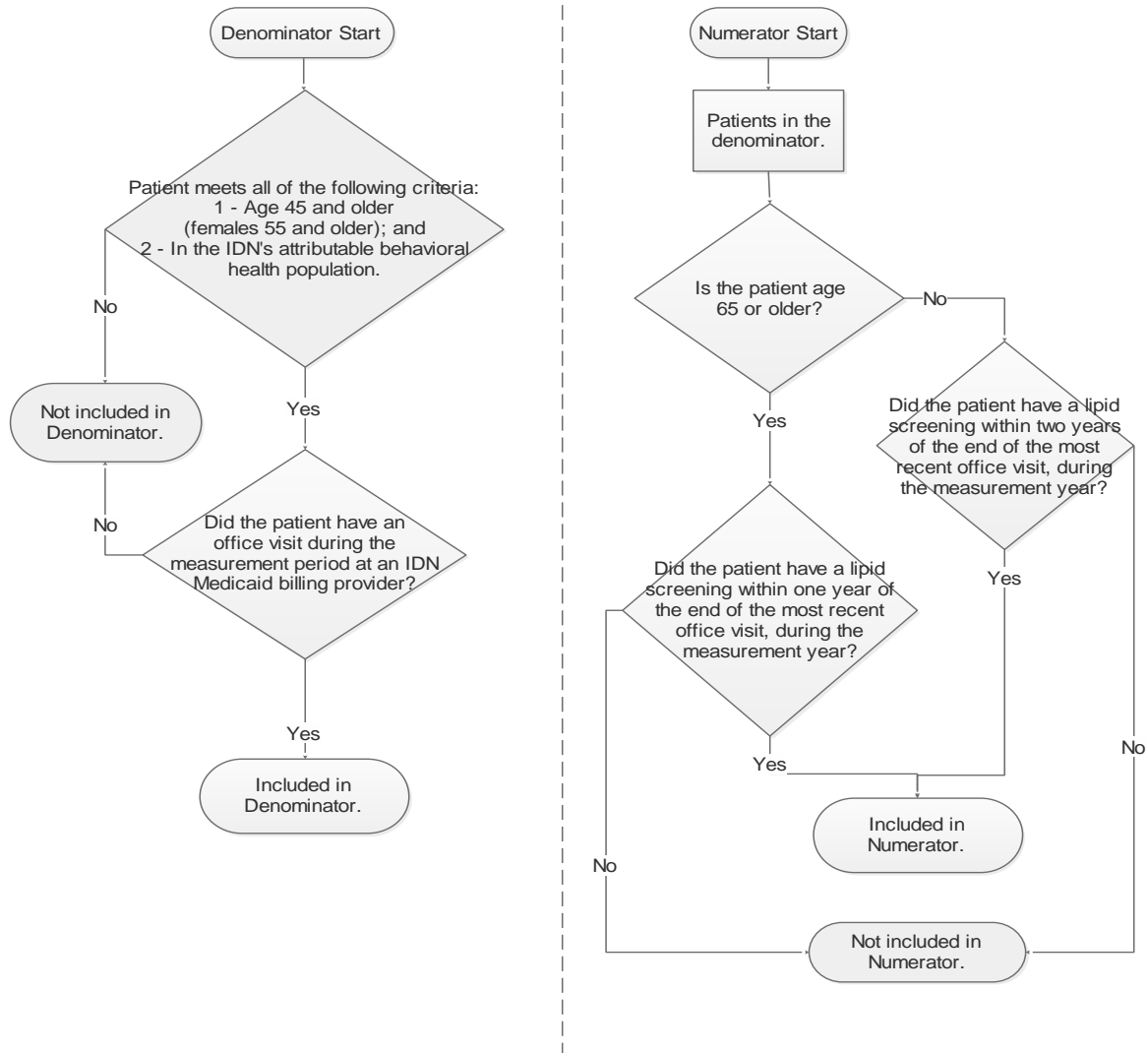
Technical Definition:

Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:



ASSESS_SCREEN.03-D: Adolescent Tobacco Use Interventions

Identifier:

ASSESS_SCREEN.03-D

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 12 through 17 seen by the IDN's primary care or behavioral health provider for a well care visit during the calendar year that are provided brief counseling or education to prevent smoking as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid patient* age 12 through 17 in the IDN's attributed behavioral health population group** with a well care visit during the measurement period at the IDN's Medicaid Billing providers.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the well care visit. Patients do not have to be continuously enrolled in NH Medicaid for the reporting period.

The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Brief Counseling and Education – Includes face-to-face or phone interactions with a care provider, print materials, videos, and computer applications.

Clinical Summary –

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/tobacco-use-in-children-and-adolescents-primary-care-interventions>

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic.

Tobacco Use – Includes any type of tobacco use.

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-D – Data Element Specifications Adolescent Tobacco Use Interventions

Identifier:

ASSESS_SCREEN.03-D-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of IDN's attributed behavioral health patients in the eligible population ages 12 through 17 that are provided brief counseling or education to prevent smoking as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the well care visit.

The well care visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Brief Counseling and Education includes face-to-face or phone interactions with a care provider, print materials, videos, and computer applications.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.03-D-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-D-RATE

Class:

Rate

Type:

Numeric

Technical Definition:

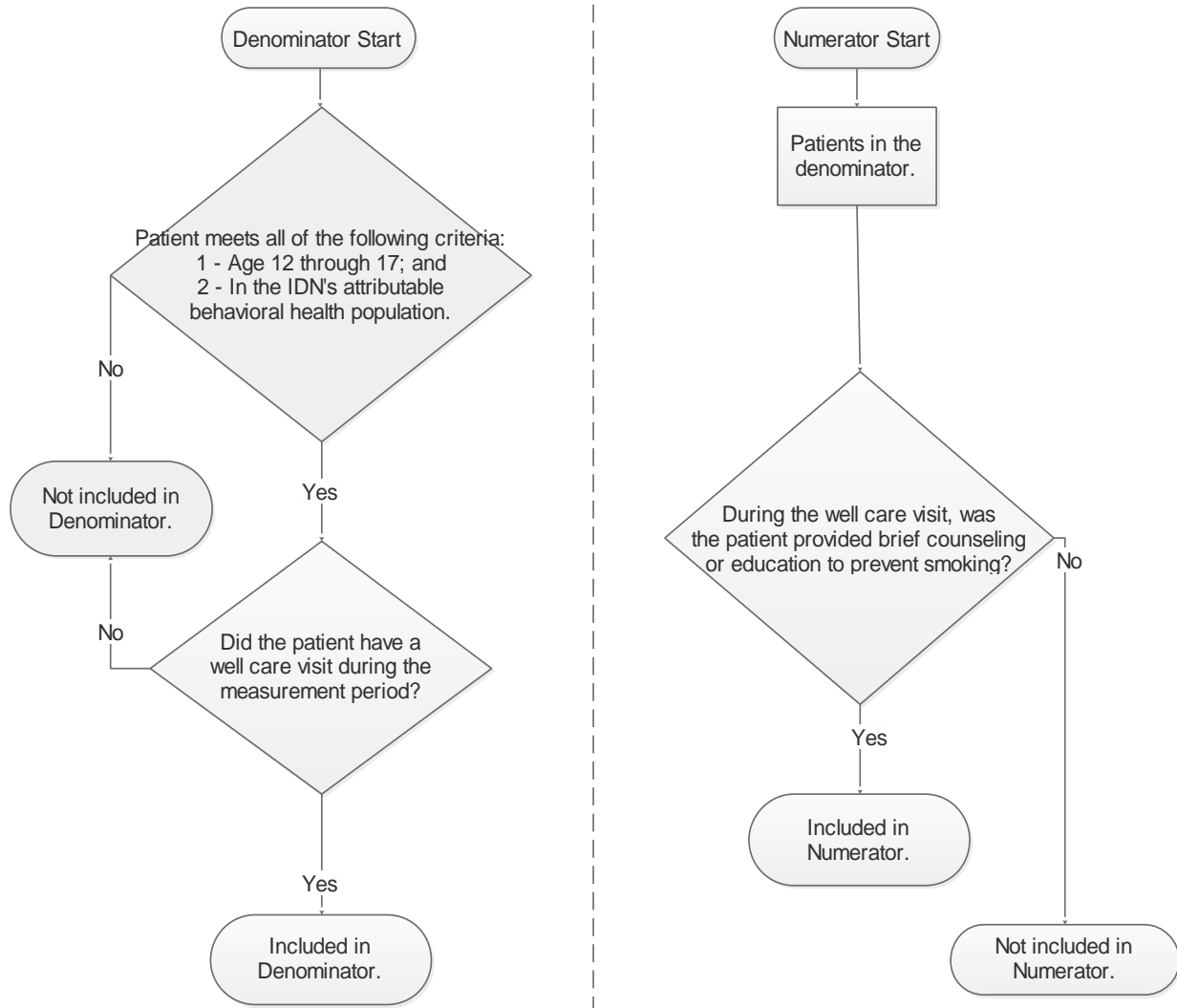
Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:

Individual Measure Flow Chart: ASSESS_SCREEN.03D
USPSTF A&B Services for BH Population
Tobacco Use Interventions



ASSESS_SCREEN.03-E: Adult Obesity Screening and Counseling

Identifier:

ASSESS_SCREEN.03-E

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 18 and older seen by the IDN's primary care or behavioral health provider for a well care visit during the calendar year who have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid patient* age 18 and older in the IDN's attributed behavioral health population group** with a well care visit during the measurement period at the IDN's Medicaid Billing providers.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the well care visit. Patients do not have to be continuously enrolled in NH Medicaid for the reporting period.

The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Applicable Referrals – Patients with a Body Mass Index ≥ 30 should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

Clinical Summary –

<https://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/obesity-in-adults-screening-and-management>

Obesity Screening – Measuring the patient’s Body Mass Index (BMI).

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic.

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-E – Data Element Specifications Adult Obesity Screening and Counseling

Identifier:

ASSESS_SCREEN.03-E-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of IDN's attributed behavioral health patients in the eligible population that have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the well care visit.

The well care visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Obesity screening will be conducted by measuring the patient's Body Mass Index (BMI).

Patients with a Body Mass Index ≥ 30 should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.03-E-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-E-RATE

Class:

Rate

Type:

Numeric

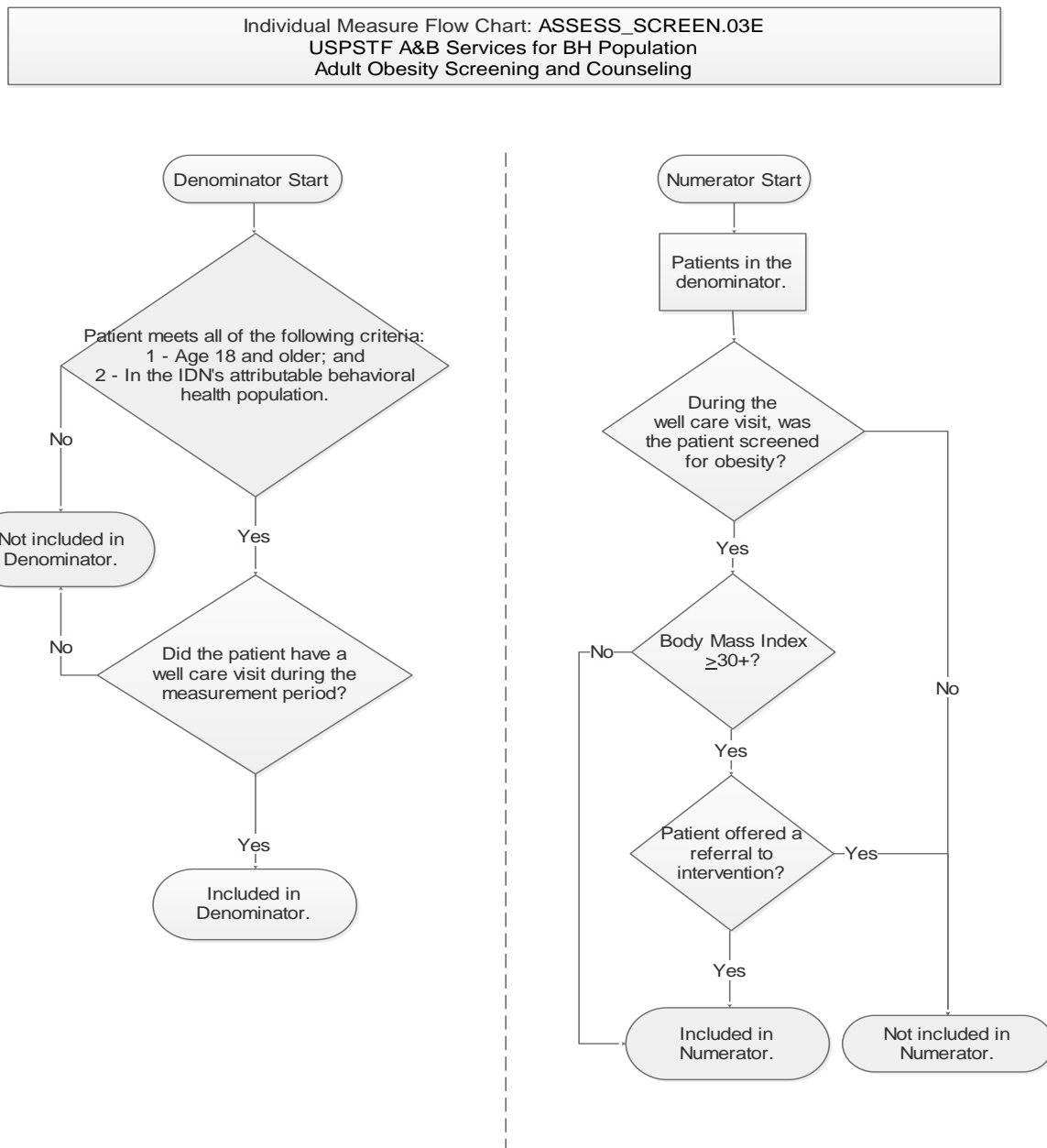
Technical Definition:

Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00 - Must be ≤ 100.00

Measure Flow:



ASSESS_SCREEN.03-F: Child Obesity Screening and Counseling

Identifier:

ASSESS_SCREEN.03-F

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of Medicaid patients in the IDN's attributed behavioral health population, age 6 through 17, seen by the IDN's primary care or behavioral health provider for a well care visit during the calendar year who have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the visit. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid patient* age 6 through 17 in the IDN's attributed behavioral health population group** with a well care visit during the measurement period at the IDN's Medicaid Billing providers.

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Attributed behavioral health population determined at the end of the reporting period. Patient's age is determined at the end of the well care visit. Patients do not have to be continuously enrolled in NH Medicaid for the reporting period.

The visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Determining Attributed Behavioral Health Population: DHHS will supply person specific detail of each IDN's attributed behavioral health population to the IDN lead or contracted designee approximately five months after the end of each measure data source time period. The IDN or contracted designee will use this file from DHHS to determine which IDN patient seen during the measure data source time period shall be considered in the behavioral health population for the reporting of this measure.

Technical Definition:

Numerator, denominator and rate are calculated per data element specifications.

Submeasures:

None.

Definitions Specific to Measure:

Applicable Referrals – Patients with a Body Mass Index \geq 95th percentile for age and gender should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

Clinical Summary –

<https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening>

Obesity Screening – Measuring the patient’s Body Mass Index (BMI).

Office Visit – Use Place of Service Codes 11 – Office, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility 72 – Rural Health Clinic.

Exclusions:

None.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

ASSESS_SCREEN.03-F – Data Element Specifications Child Obesity Screening and Counseling

Identifier:

ASSESS_SCREEN.03-F-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

The number of IDN's attributed behavioral health patients in the eligible population that have an obesity screening and applicable referrals offered as indicated in the patient's electronic health record (EHR) or other tracking system at the end of the well care visit.

The well care visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Obesity screening will be conducted by measuring the patient's Body Mass Index (BMI).

Patients with a Body Mass Index \geq 95th percentile for age and gender should be offered a referrals to an intensive multi-component behavioral health intervention to promote improvement in weight.

Business Rules:

- Must be \geq 0.000

Identifier:

ASSESS_SCREEN.03-F-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.03-F-RATE

Class:

Rate

Type:

Numeric

Technical Definition:

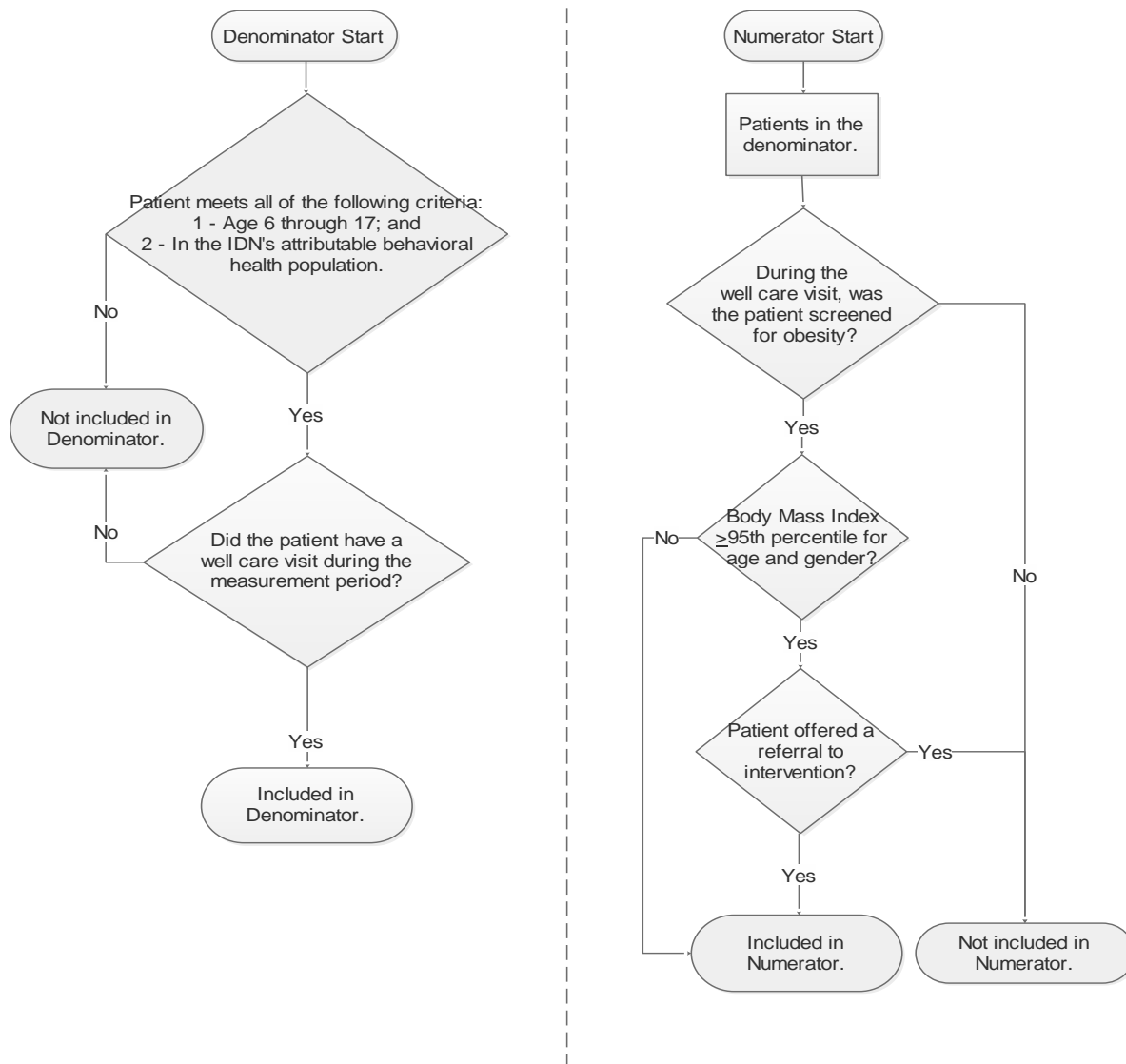
Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00
- Must be ≤ 100.00

Measure Flow:

Individual Measure Flow Chart: ASSESS_SCREEN.03F
USPSTF A&B Services for BH Population
Child Obesity Screening and Counseling



ASSESS_SCREEN.04 - Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by the IDN's Medicaid Billing Providers

Identifier:

ASSESS_SCREEN.04

Summary of Measure Changes:

This is a new measure

Last Modified:

This is a new measure

Measure Description:

Percent of positive screenings for tobacco use for Medicaid patients age 18 and older seen by the IDN's primary care or behavioral health providers for an office or community-based visit during the six month measurement period, who received cessation counseling intervention as documented in the patient's electronic health record (EHR) on the date of the positive screening. IDNs must ensure that all primary care or behavioral health provider partners report data for this measure to the extent the criteria for inclusion in the measure is met.

Eligible Population:

Any NH Medicaid patient age * 18 years and older**, who during a visit at the IDN's Medicaid billing provider:

- Received a screening for tobacco use; and
- Received a positive screening for tobacco use.

The visit must have:

- Occurred in the measure data reporting period;
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider

*Includes NH Medicaid patients enrolled in Fee-for-Service, Managed Care Organizations, or Qualified health plans.

** Patient's age determined as of the date of the last visit at the IDN's Medicaid billing provider.

Technical Definition:

See numerator and denominator for greater details.

Definitions Specific to Measure:

Appropriate Follow-up Plan – Documented plan following the requirements described in the DSRIP Core Competency Project: B1 Integrated Healthcare.

Cessation Counseling – Includes brief counseling and/or pharmacotherapy.

Office and Community Based Visit – Use Place of Service Codes 03 – School, 04- Homeless Shelter, 11 – Office, 12-Home, 13 – Assisted Living Facility, 14 – Group Home, 15 – Mobile Unit, 16 – Temporary Lodging, 17 – Walk-in Retail Clinic, 18 – Place of Employment, 19 – Off Campus-Outpatient Hospital, 22 – On Campus-Outpatient Hospital, 49 – Independent Clinic, 50 – Federally Qualified Health Center, 53 – Mental Health Center, 57 – Non-Residential Substance Abuse Treatment Facility, 62 - Comprehensive Outpatient Rehabilitation Facility, 71 – Public Health Clinic, 72 – Rural Health Clinic

Positive Screenings – Screening results that indicate a member is a tobacco user.

Screenings – Tools used for this measure should be a part of the comprehensive core assessment documented in the IDN’s approved implementation project plan and protocols for DSRIP Core Competency Project: B1 Integrated Healthcare.

Unit of Analysis:

Percent of screenings.

Exclusions:

Patients in hospice.

Data Source/Type:

Administrative Data: Electronic Health Records

Contract Reference:

CMS NH DSRIP Protocols C and D

Measure Submission Frequency: Semi-annually.

Data Source Life Span:

2018-01-01 - 2020-12-31

Measure Data Source Time Period:

6 months

Measure Data Source Period Preview:

Submission #1: 2018-01-01 - 2018-06-30

Submission #2: 2018-07-01 - 2018-12-31

Submission #3: 2019-01-01 - 2019-06-30

Submission #4: 2019-07-01 - 2019-12-31

Submission #5: 2020-01-01 - 2020-06-30

Submission #6: 2020-07-01 - 2020-12-31

Submission Due Date Lag Period:

3 months.

Measure Due Date Previews:

Submission #1: 2018-10-01

Submission #2: 2019-04-01

Submission #3: 2019-10-01

Submission #4: 2020-04-01

Submission #5: 2020-10-01

Submission #6: 2021-04-01

ASSESS_SCREEN.04 – Data Element Specifications

Identifier:

ASSESS_SCREEN.04-NUM

Class:

Numerator

Type:

Numeric

Technical Definition:

Members in the eligible population whose most recent office visit with the IDN's Medicaid Billing Provider shows evidence in the patient's electronic health record (EHR) or other electronic tracking system of cessation counseling intervention on the same day as the positive screening for tobacco use.

The most recent visit must have:

- Occurred in the measure data reporting period (See Measure Data Source Period Preview);
- Occurred in an office setting;
- Been for a NH Medicaid billable service; and
- Been conducted by a provider at a primary care practice, or behavioral health provider.

Business Rules:

- Must be ≥ 0.000

Identifier:

ASSESS_SCREEN.04-DEN

Class:

Denominator

Type:

Numeric

Technical Definition:

The number of positive screenings in the Eligible Population.

Business Rules:

- Must be ≥ 1.00

Identifier:

ASSESS_SCREEN.04-RATE

Class:

Rate

Type:

Numeric

Technical Definition:

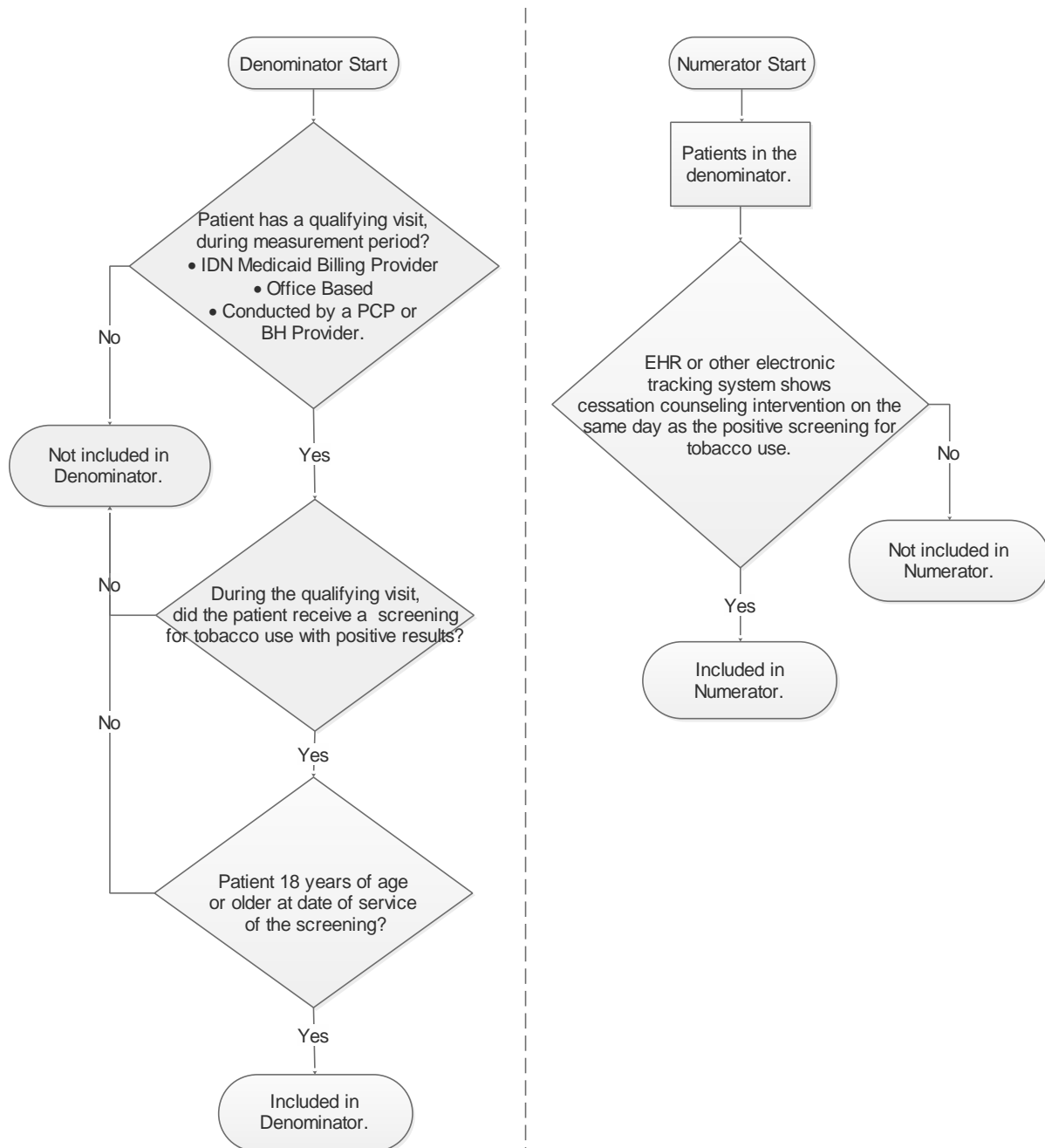
Numerator/Denominator*100 (percent rounded to 1 decimal place)

Business Rules:

- Must be ≥ 1.00 ; Must be ≤ 100.00

Measure Flow:

Individual Measure Flow Chart: ASSESS_SCREEN.04
Medicaid Billing IDN Providers Smoking and Tobacco Cessation Screening
and Counseling for Tobacco Users



Appendix B: Measurement Timeline

The table below shows the timeline for publication of measures. The date at the top of each column is the target month for publication. The values in the cells under publication target are the time periods that will be reported on when the measure is published. Also included is whether the measure is tied to payment for reporting (P4R) or for performance (P4P).

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|---|--|--|--------------------------|----------|--------------------------|--------------------|----------------------|----------|--------------------------|--------------------|--------------------------|----------|--------------------------|--------------------|----------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| ASSESS_SCREEN.01 IDN Submitted measure | Use of Comprehensive Core Standardized Assessment Process by IDN Primary Care and BH Providers | P4R Jul 17-Dec 17 | P4R Jan 18-Jun 18 | | P4R Jul 18-Dec 18 | | P4P Jan 19-Jun 19 | | P4P Jul 19-Dec 19 | | P4P Jan 20-Jun 20 | | P4P Jul 20-Dec 20 | | |
| ASSESS_SCREEN.02 IDN Submitted measure | Appropriate Follow-Up Documented for Positive Screenings for Potential Substance Use Disorder and/or Depression by IDN Primary Care and BH Providers | P4R Jul 17-Dec 17 | P4R Jan 18-Jun 18 | | P4R Jul 18-Dec 18 | | P4P Jan 19-Jun 19 | | P4P Jul 19-Dec 19 | | P4P Jan 20-Jun 20 | | P4P Jul 20-Dec 20 | | |
| ASSESS_SCREEN.03 IDN Submitted measure | Selected USPSTF Services for Behavioral Health Population | See Submeasures below | | | | | | | | | | | | | |
| ASSESS_SCREEN.03_SUB_A | Female intimate partner violence screening and intervention | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|--|---|--|----------------------|----------|----------------------|----------------|----------------------|----------|----------------------|----------------|----------------------|----------|----------------------|----------------|----------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| ASSESS_SCREEN.03_SUB_B | High blood pressure screening | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| ASSESS_SCREEN.03_SUB_C | Lipid screening | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| ASSESS_SCREEN.03_SUB_D | Adolescent tobacco use intervention or prevention | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| ASSESS_SCREEN.03_SUB_E | Adult obesity screening and intervention | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| ASSESS_SCREEN.03_SUB_F | Child obesity screening and intervention | | | | | P4R CY 2018 | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| ASSESS_SCREEN.04 | Tobacco Cessation Screening and Counseling for Tobacco Users by IDN Primary Care and BH Providers | | P4R Jan 18-Jun 18 | | P4R Jul 18-Dec 18 | | P4P Jan 19-Jun 19 | | P4P Jul 19-Dec 19 | | P4P Jan 20-Jun 20 | | P4P Jul 20-Dec 20 | | |
| CARE.01 DHHS Calculated Measure | Mental Health-Focused HEDIS Measures: Summary Score | See Submeasures below | | | | | | | | | | | | | |
| CARE.01_Sub_A | Antidepressant Medication Management - Continuation Phase | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.01_Sub_B | Adherence to Antipsychotic Medication for Individuals with Schizophrenia | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|---|--|--|----------|----------|----------|--|-----------------------------------|----------------------|----------|--|-----------------------------------|----------------------|----------|--|-----------------------------------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| CARE.01_Sub_D | Metabolic Monitoring for Children and Adolescents on Antipsychotics | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.01_Sub_E | Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic medications | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.01_Sub_F | Diabetes Monitoring for People with Diabetes and Schizophrenia | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.02 DHHS Calculated Measure | Adolescent (Age 12-21) Well-Care Visits | | | | | | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| CARE.03 | Physical Health-Focused HEDIS Measures for Behavioral Health Population: Summary Score | See Submeasures below | | | | | | | | | | | | | |
| CARE.03_Sub_A Hybrid Measure DHHS creates Patient lists for the IDN's to submit required data on. | Controlling High Blood Pressure | | | | | DHHS to Provide Patient List for CY 2018 | P4R IDN's submit required data | | | DHHS to Provide Patient List for CY 2019 | P4P IDN's submit required data | | | DHHS to Provide Patient List for CY 2020 | P4P IDN's submit required data |

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|---|--|--|----------|----------|----------|--|--------------------------------|----------------------|----------------------|--|--------------------------------|----------------------|----------------------|--|--------------------------------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| CARE.03_Sub_C Hybrid Measure DHHS creates Patient lists for the IDN's to submit required data on. | Comprehensive Diabetes Care - HbA1c Control <8.0% | | | | | DHHS to Provide Patient List for CY 2018 | P4R IDN's submit required data | | | DHHS to Provide Patient List for CY 2019 | P4P IDN's submit required data | | | DHHS to Provide Patient List for CY 2020 | P4P IDN's submit required data |
| CARE.03_Sub_F DHHS Calculated Measure | Physical Health-Focused HEDIS Measures for Behavioral Health Population: Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.03_Sub_G DHHS Calculated Measure | Physical Health-Focused HEDIS Measures for Behavioral Health Population: Asthma Medicaid Ratio | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| CARE.04 DHHS Calculated Measure | Initiation of Alcohol and Other Drug Dependence Treatment | | | | | | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| CARE.05 DHHS Calculated Measure | Engagement of Alcohol and Other Drug Dependence Treatment | | | | | | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| CMHC.02 DHHS Calculated Measure | Community Mental Health Center First Follow-up Visit Timeliness | | | | | P4P Jan 19-Jun 19 | | | P4P Jul 19-Dec 19 | | P4P Jan 20-Jun 20 | | P4P Jul 20-Dec 20 | | |

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|---|---|--|----------|--------------------------|----------|--------------------------|----------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|--------------------|----------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| CMHC.03 DHHS Calculated Measure | Community Mental Health Center First Psychiatrist Visit Timeliness | | | | | P4P Jan 19-Jun 19 | | | P4P Jul 19-Dec 19 | | P4P Jan 20-Jun 20 | | P4P Jul 20-Dec 20 | | |
| EXPERIENCE.01 | Experience of Care Survey: Care Coordination Composite Score | | | | | | | | P4P Sep 19-Mar 20 | | | | P4P Sep 20-Mar 21 | | |
| HOSP_ED.01 DHHS Calculated Measure | Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population | | | P4P Jul 17-Jun 18 | | P4P CY 2018 | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| HOSP_ED.02 DHHS Calculated Measure | Potentially Avoidable Emergency Department Visits | | | P4P Jul 17-Jun 18 | | P4P CY 2018 | | P4P | | P4P CY 2019 | | P4P | | P4P CY 2020 | |
| HOSP_ED.03 DHHS Calculated Measure | Follow-up After Emergency Department Visit for Mental Illness Within 30 Days | | | | | | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| HOSP_ED.04 DHHS Calculated Measure | Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days | | | | | | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |

| Reference Number | Name | Measure Publication Dates/Payment Basis/Measurement Period | | | | | | | | | | | | | |
|---|---|--|----------|--------------------------|----------|--|---------------------------------------|--------------------------|----------|--|---------------------------------------|--------------------------|----------|--|---------------------------------------|
| | | Apr-2018 | Oct-2018 | Dec-2018 | Apr-2019 | Jul-2019 | Oct-2019 | Dec-2019 | Apr-2020 | Jul-2020 | Oct-2020 | Dec-2020 | Apr-2021 | Jul-2021 | Oct-2021 |
| HOSP_INP.01 DHHS Calculated Measure | Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days | | | | | | | | | P4P CY 2019 | | | | P4P CY 2020 | |
| HOSP_INP.02 Hybrid Measure DHHS creates Patient lists for the IDN's to submit required data on. | Timely Transmission of Transition Record After Hospital Discharge | | | | | DHHS to Provide Patient List for CY 2018 | P4R IDN's submit required data | | | DHHS to Provide Patient List for CY 2019 | P4P IDN's submit required data | | | DHHS to Provide Patient List for CY 2020 | P4P IDN's submit required data |
| HOSP_INP.03 DHHS Calculated Measure | Follow-up After Hospitalization for Mental Illness Within 7 Days | | | P4P Jul 17-Jun 18 | | P4P CY 2018 | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| HOSP_INP.04 DHHS Calculated Measure | Follow-up After Hospitalization for Mental Illness Within 30 Days | | | P4P Jul 17-Jun 18 | | P4P CY 2018 | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |
| OPIOIDRX.01 DHHS Calculated Measure | Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose for 15 or more days in year | | | P4P Jul 17-Jun 18 | | P4P CY 2018 | | P4P Jul 18-Jun 19 | | P4P CY 2019 | | P4P Jul 19-Jun 20 | | P4P CY 2020 | |



Transforming Healthcare in the Granite State